

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08419

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		d. STREET ADDRESS <u>3939 1/2 GREENCASTLE</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>H.</u> Last <u>MAUNING</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/88</u> 19 <u>79</u>
9. AGE (In years, last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coleman Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Holy Cross Hosp. chart records, Silver Spg., Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Cerebral edema</u>			
DUE TO (b) <u>Cerebral contusions</u>			
DUE TO (c) <u>Vehicular accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drove his car into rear of a truck on Route 495.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:30 a.m. 6/21 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/27/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Burial</u>		23b. DATE THEREOF <u>6-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>-----</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethel, North Carolina</u>	
24. FUNERAL DIRECTOR <u>HYSONG FUNERAL HOME</u> ADDRESS <u>1300-N 31-NW Washington, DC</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
PER: <u>James M. Hysong</u>		DATE <u>JUN 29 1967</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08425

CERTIFICATE OF DEATH

08418

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 10906 Jarboe Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Joseph Last Malone		4. DATE OF DEATH Month June Day 13 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15, 1895	9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Supervisor		10b. KIND OF BUSINESS OR INDUSTRY D. C. Govt.		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Patrick Malone		14. MOTHER'S MAIDEN NAME Mary Mahoney Mahaney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 578-36-3447		17. INFORMANT Louise M. Malone	
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lungs DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 10 years 2 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/13/67 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1949 to 6/13 , 19 67 , that (I) was lost saw the deceased alive on 6/9 , 19 67 , and that death occurred at 2:30 PM , from causes and on the date stated above.					
22a. SIGNATURE John E. Everett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/67	
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT		22d. ADDRESS 9400 CONN. AVE Kensington			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery	
23d. LOCATION (City or Town) (County) (State) Fairland, Maryland					
24. FUNERAL DIRECTOR John B. Warner		25a. REC'D BY REGISTRAR June 15 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08427

CERTIFICATE OF DEATH

08420

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				d. STREET ADDRESS <u>106 Rockdale Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. NAME OF DECEASED (Type or print) <u>AGNES D. MAZUR</u>				4. DATE OF DEATH <u>6/24/67</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/18/92</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>EDWARD DILLON</u>			
14. MOTHER'S MAIDEN NAME <u>JOHANNA GALLAGHER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-46-9338</u>				17. INFORMANT Address <u>MARGARET M. DOYLE SAME AS #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> DUE TO (b) <u>Diabetic Acidosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1967</u> to <u>June 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1967</u> , and that death occurred at <u>3:45 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Edward J. Richards</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. RICHARDS</u>				22d. ADDRESS <u>10110 Ga. Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING MD.</u>	
24. FUNERAL DIRECTOR <u>Francis Collins</u>				25a. REC'D BY REGISTRAR <u>3521-142 #70</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>JUN 28 1967</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08428

08421

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				d. STREET ADDRESS <u>105 UNIVERSITY BLVD. E. APT. 201</u>			
3. NAME OF DECEASED (Type or print) <u>MR. RALPH CHARLES McCAULEY</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2-25-41</u>		9. AGE (In years last birthday) <u>26</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SILVER BURG ELECTRIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT McCAULEY</u>				14. MOTHER'S MAIDEN NAME <u>EDITH ROSELE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES NAVY '59-62</u>		16. SOCIAL SECURITY NO. <u>215-39-4337</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330X</u> DUE TO <u>Circulatory collapse</u> (b) <u>Cushing's ulcer</u> DUE TO <u>Ruptured saccular intracerebral aneurysm</u> (c) <u>48 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> , 19 <u>67</u> , to <u>6/14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/13</u> , 19 <u>67</u> , and that death occurred at <u>8:30 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John Thomas Lord</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>John Thomas Lord</u>	
22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/15/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City or town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>JAMES T. RYAN, Inc. 317 W. AVE., S.E.</u>				25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08429

CERTIFICATE OF DEATH

08424

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTG.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPENCERVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPENCERVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15739 GOOD HOPE ROAD				d. STREET ADDRESS 15739 GOOD HOPE ROAD			
3. NAME OF DECEASED (Type or print) First Jason Middle Mc Nalley Last June				4. DATE OF DEATH Month June Day 15 Year 1967			
5. SEX Male	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) GEROGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-14-3852		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO Hypertensive Cardid-vascular disease (c) not known						INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recent Cerebral thromboses (CVA)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from June 9 , 1967, to June 15 , 1967, that (1) (we) last saw the deceased alive on June 14 1967, and that death occurred at 3:10 M. from causes and on the date stated above.							
22a. SIGNATURE John R. Spencer				22b. DATE SIGNED 6-15-67		22c. PHYSICIAN'S NAME (Type) John R. Spencer	
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/>		22f. STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/19/67		23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL CEM.		23d. LOCATION (City or Town) (County) (State) SANDY SPRINGS, MD	
24. FUNERAL DIRECTOR ROBERT L. S. NOWDEN				25a. REC'D BY REGISTRAR JUN 22 1967		25b. REGISTRAR'S SIGNATURE John R. Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

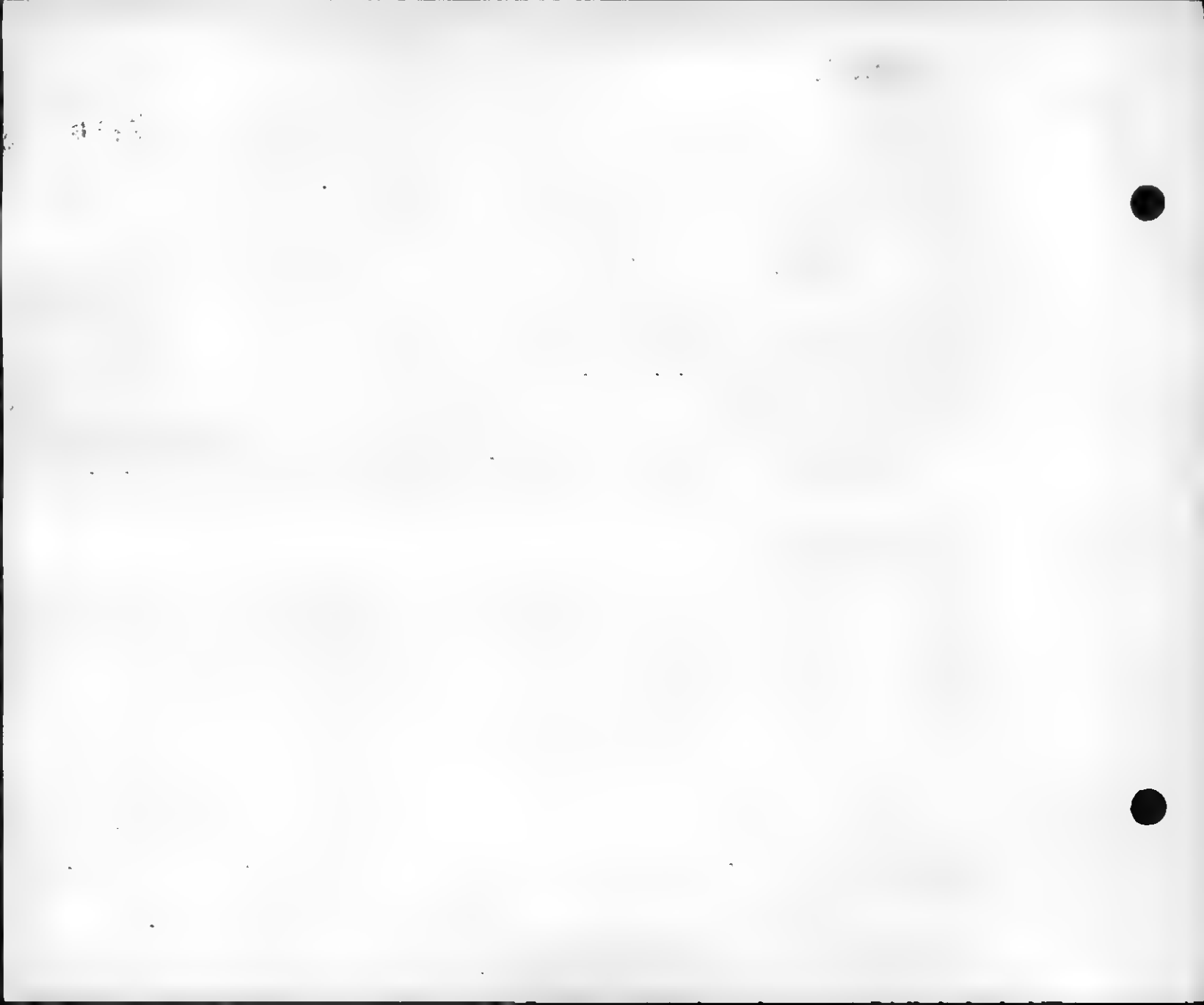
CERTIFICATE OF DEATH

08425

28430

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Washington D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 144 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS 7 E Adams Street			
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Meinberg				4. DATE OF DEATH Month June Day 2 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-91		9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 1 Days 6 Hours 7 Min 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired electrician				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State or foreign country) Washington D.C.	
13. FATHER'S NAME Adam Meinberg				14. MOTHER'S MAIDEN NAME Mary La Port			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Army - WWII				16. SOCIAL SECURITY NO 578-58-2312		17. INFORMANT Mrs. Roger Cornphre Address 7616 Georgia Avenue NW Washington, D.C.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach - Metastatic 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 4/19 , 19 67 to 6/2 , 19 67 that (1) (we) last saw the deceased alive on 6/1/67 , 19 67 , and that death occurred at 3:20 AM , from causes and on the date stated above.							
22a. SIGNATURE Raymond O. West				22b. DATE SIGNED June 2, 1967		22c. PHYSICIAN'S NAME (Type) Raymond O. West	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24. FUNERAL DIRECTOR Glen Carter, Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR JUN 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

28431

08426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

closed & covered (Dr. Pappas) 7/11/67

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Carroll</u> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lebanon</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>182 Penna Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Lillie Irene Meyers</u>		4 DATE OF DEATH <u>6-11</u> 19 <u>67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-6-86</u>
9 AGE (In years last birthday) <u>81</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Emanuel Hollenbush</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Mull</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>220-46-1990</u>	
17 INFORMANT <u>Edna C. Pappas</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (b) <u>ASHD congestive failure</u> (c) <u>due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>many yrs.</u> <u>several mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <u>Dr. Pappas</u> attended the deceased from <u>6/10</u> 19 <u>67</u> to <u>June 11</u> 19 <u>67</u> , that <u>we</u> (we) last saw the deceased alive on <u>June 11</u> 19 <u>67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Marvin Wadler</u>		22b DATE SIGNED <u>6/11/67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d ADDRESS <u>8218 Wisconsin Av. Bethesda</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>6-14-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Madon Branch</u>	23d LOCATION (City or town) (County) (State) <u>Westminster Carroll Md</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gathursburg</u>		25a REC'D BY REGISTRAR <u>June 14 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08432

08427

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennington</u>				c. LENGTH OF STAY IN b. <u>35 days</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kennington Gardens Nursing Home</u>				e. STREET ADDRESS <u>4224 Oglethorpe St.</u>									
3. NAME OF DECEASED (Type or print) <u>SARAH M. MILLER</u>				4. DATE OF DEATH <u>6-5-1967</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 21, 1885</u>							
9. AGE (In years last birthday) <u>81</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State or foreign country) <u>Indiana</u>							
13. FATHER'S NAME <u>James Van Buskirk</u>				14. MOTHER'S MAIDEN NAME <u>Zeytha Burton</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>5-77-12-475-3</u>		17. INFORMANT <u>James B. Seeders</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, acute</u> 4901 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arterio-sclerosis, genl.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>4 hrs.</u> <u>10 yrs. ?</u>							
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident - 7 wks</u>							
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 30, 1967</u> to <u>June 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1967</u> , and that death occurred at <u>11:37 PM</u> , from causes and on the date stated above.													
22a. SIGNATURE <u>Philip H. Varner, M.D.</u>				22b. DATE SIGNED <u>6-6-67</u>		22c. PHYSICIAN'S NAME (Type) <u>10620 Ma. Ave., Wheaton, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-8-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>							
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25. REC'D BY REGISTRAR <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>									

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

JUN 12 1967



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08433

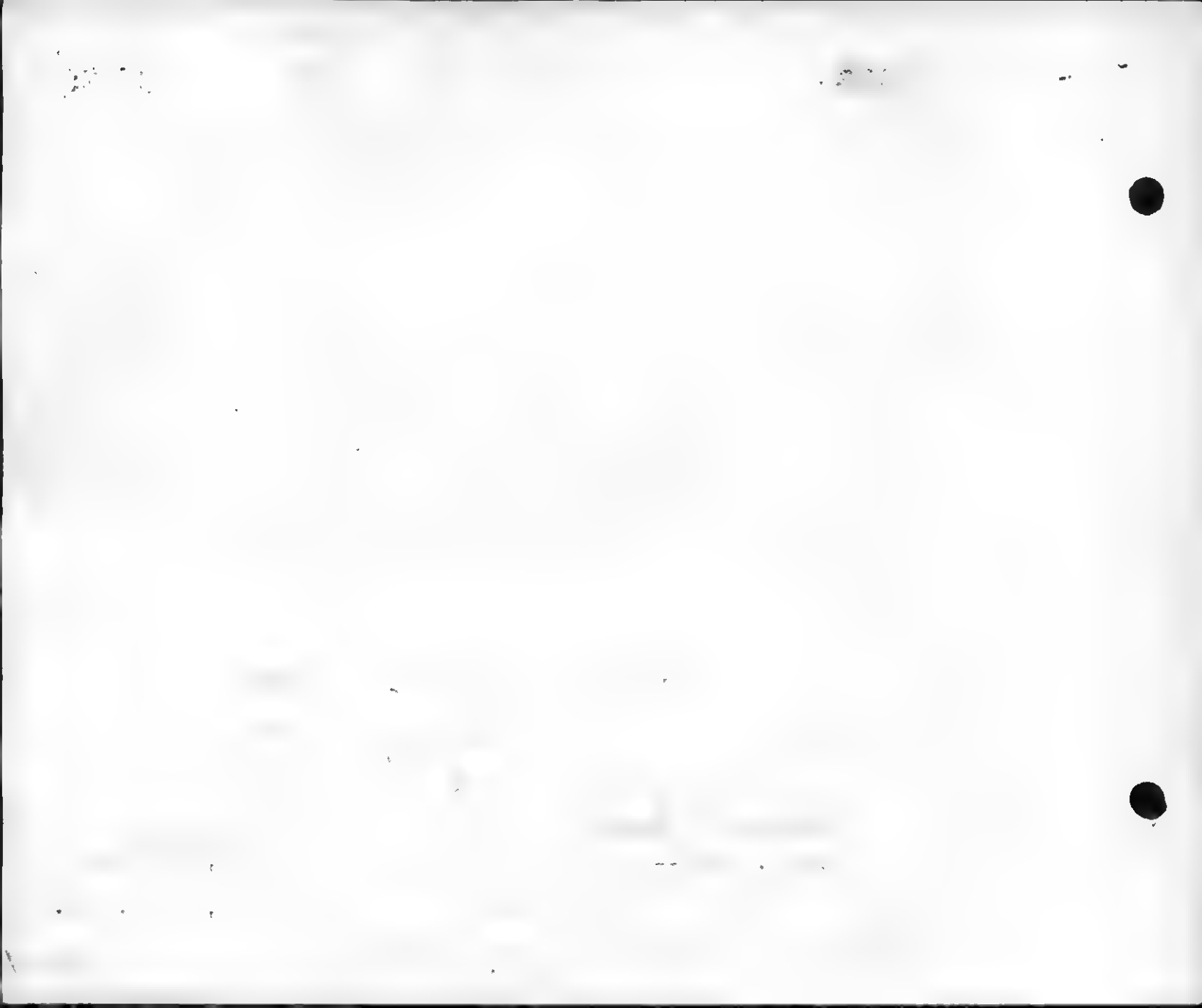
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <i>Maryland</i> b COUNTY <i>Montgomery</i>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Bethesda</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>		d STREET ADDRESS <i>436 E. Diamond Ave.</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Eugene Townsend Mitchell</i>		4 DATE OF DEATH Month Day Year <i>June 2 1967</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>3/8/34</i>
9 AGE in years last birthday <i>33</i> yrs		10 UNDER 1 YEAR Months Days <i>33</i>	11 UNDER 24 HRS Hours Min. <i>33</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bake-shop</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Safeway Stores</i>	
11 BIRTHPLACE (State or foreign country) <i>Virginia</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>Hugh Mitchell</i>		14 MOTHER'S MAIDEN NAME <i>Mabel Payne</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>217-32-1320</i>	
17 INFORMANT <i>Wife-Ruth</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac tamponade</i> DUE TO (b) <i>Due to perforation aorta and left atrium</i> DUE TO (c) <i>Due to bullet wound heart</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Shot self in chest - 22 cal. Pistol</i>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>12:00 PM 6/2 1967</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.) <i>Home</i>	20f (City or town) (County) (State) <i>Gaithersburg Mont. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Underdetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>6/5/67</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>6/8/67</i>	
ADDRESS <i>1331 Rockville Road, Rockville, Maryland</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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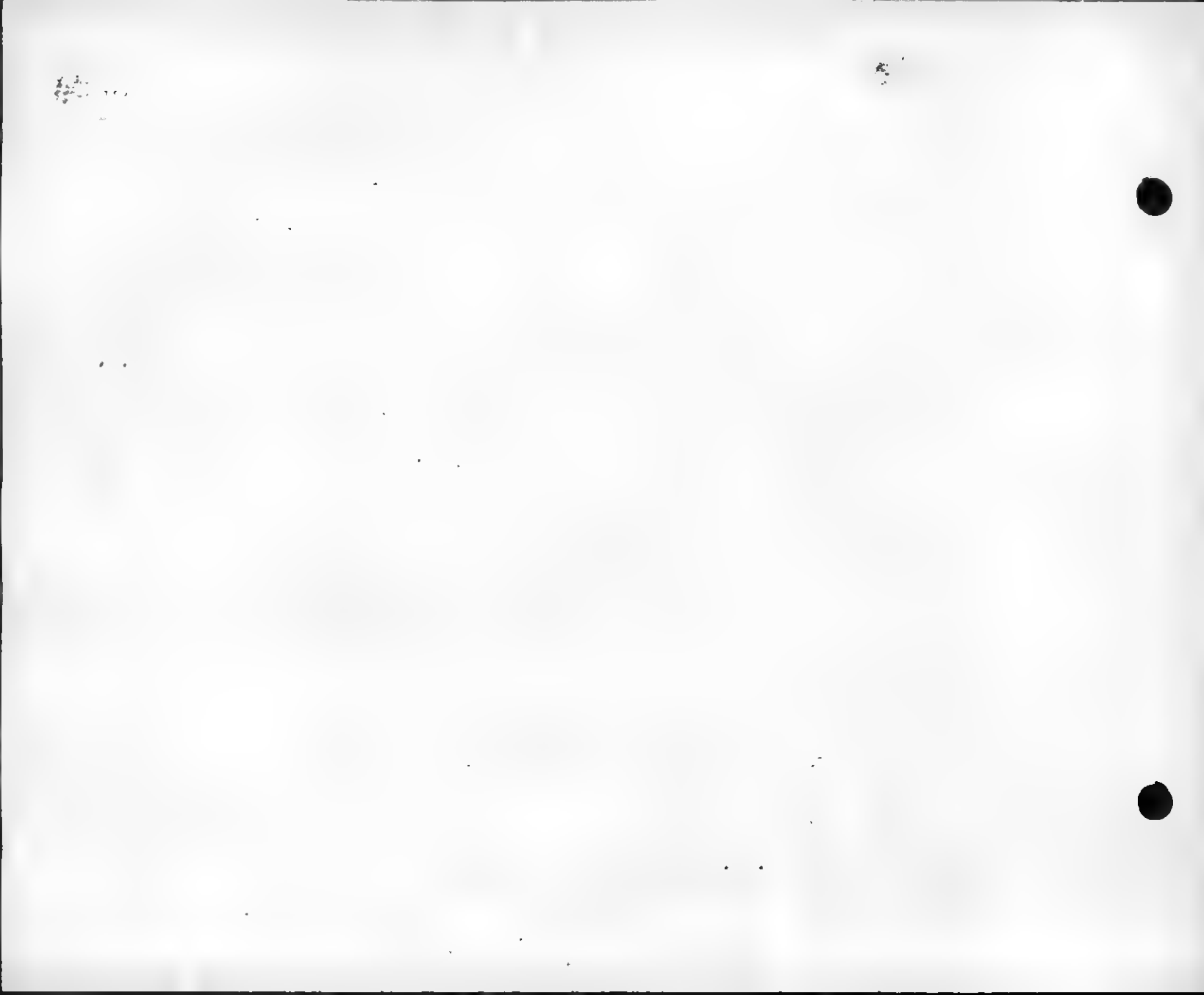
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08434

CERTIFICATE OF DEATH

08429

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 301 Giddings Street	
3. NAME OF DECEASED (Type or print) Gerry Ellis Monroe		4. DATE OF DEATH Month June Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 June 1967
9. AGE (In years last birthday) yrs. 00 Months 15 Days 00 Hours 00 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Gregory Eugene Monroe	
14. MOTHER'S MAIDEN NAME Mayrl J. Darm		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Gregory G. Monroe, Annapolis, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tracheo-esophageal fistulae with extensive aspiration pneumonitis 7547 DUE TO (b) Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Multiple congenital Anomalies		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from 5 June , 19 67 , to 17 June , 19 67 , that it (we) last saw the deceased alive on 17 June , 19 67 , and that death occurred at 5:45 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Ronald W. Swanger</i>		22b. DATE SIGNED 18 June 1967	
22c. PHYSICIAN'S NAME (Type) LCDR R. F. SWANGER, MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-19-67	23c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland
24. FUNERAL DIRECTOR John M. Taylor & Sons		25a. REC'D BY REGISTRAR 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

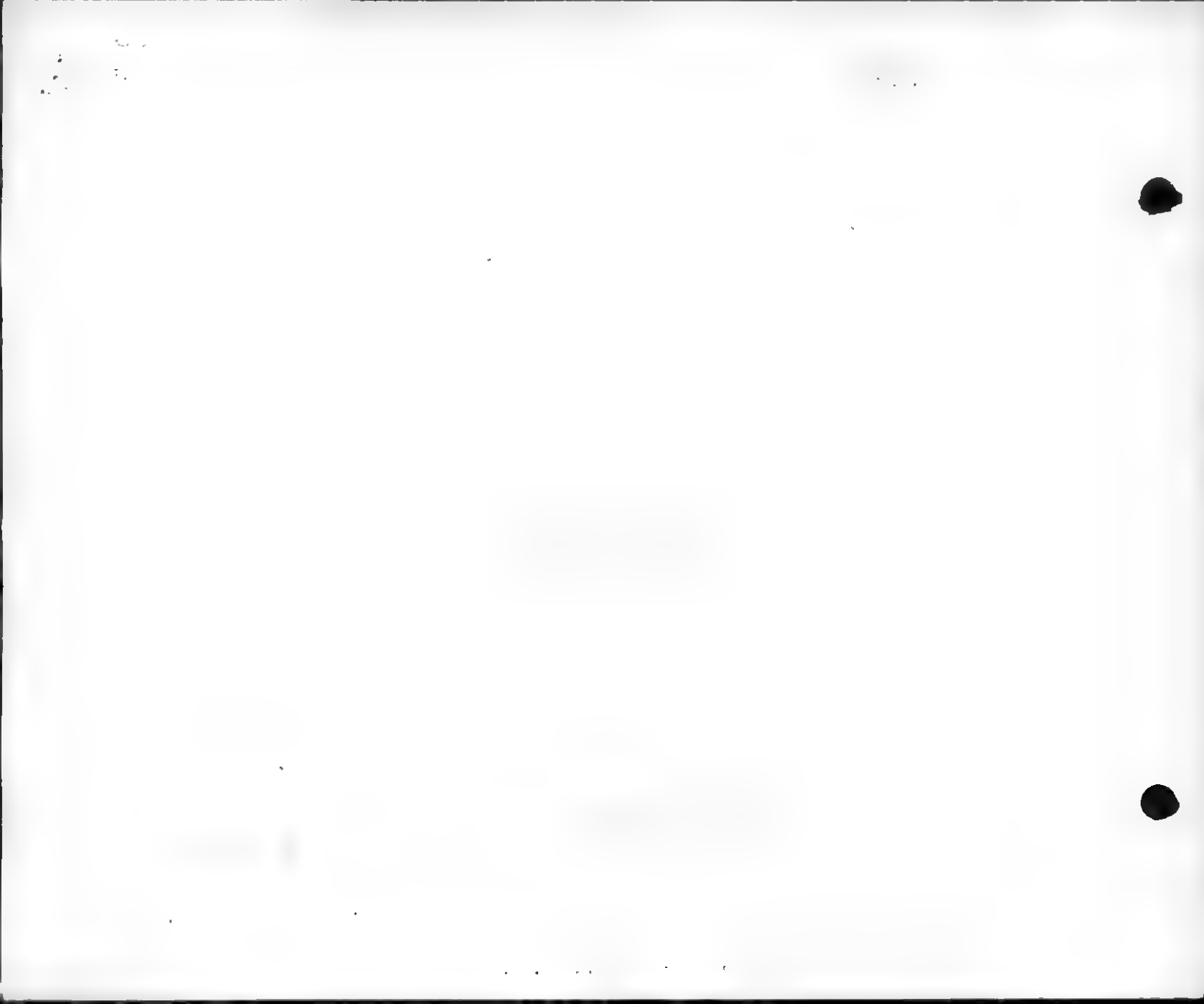
08435

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08430

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11802 Idlewood Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Moore</u>		4 DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/4/12</u>
9 AGE (In years last birthday) <u>55</u> yrs		10 UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI CAB DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11 BIRTHPLACE (State or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Daniel R. Moore</u>		14 MOTHER'S MAIDEN NAME <u>Alice M. Smith</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>579-01-9361</u>	
17 INFORMANT <u>MRS. Doris B. Moore, 2a, b, c, d Above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction Acute - 4 hr.</u>			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Occlusion - Acute - 4 hr.</u>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Ball</u> M.D.		22. DATE SIGNED <u>6/10/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12 Jun 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24 FUNERAL DIRECTOR <u>Rinaldi Funeral Home, Inc. Wash., D.C.</u>		25a. DECEASED BY REGISTRAR <u>JUN 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

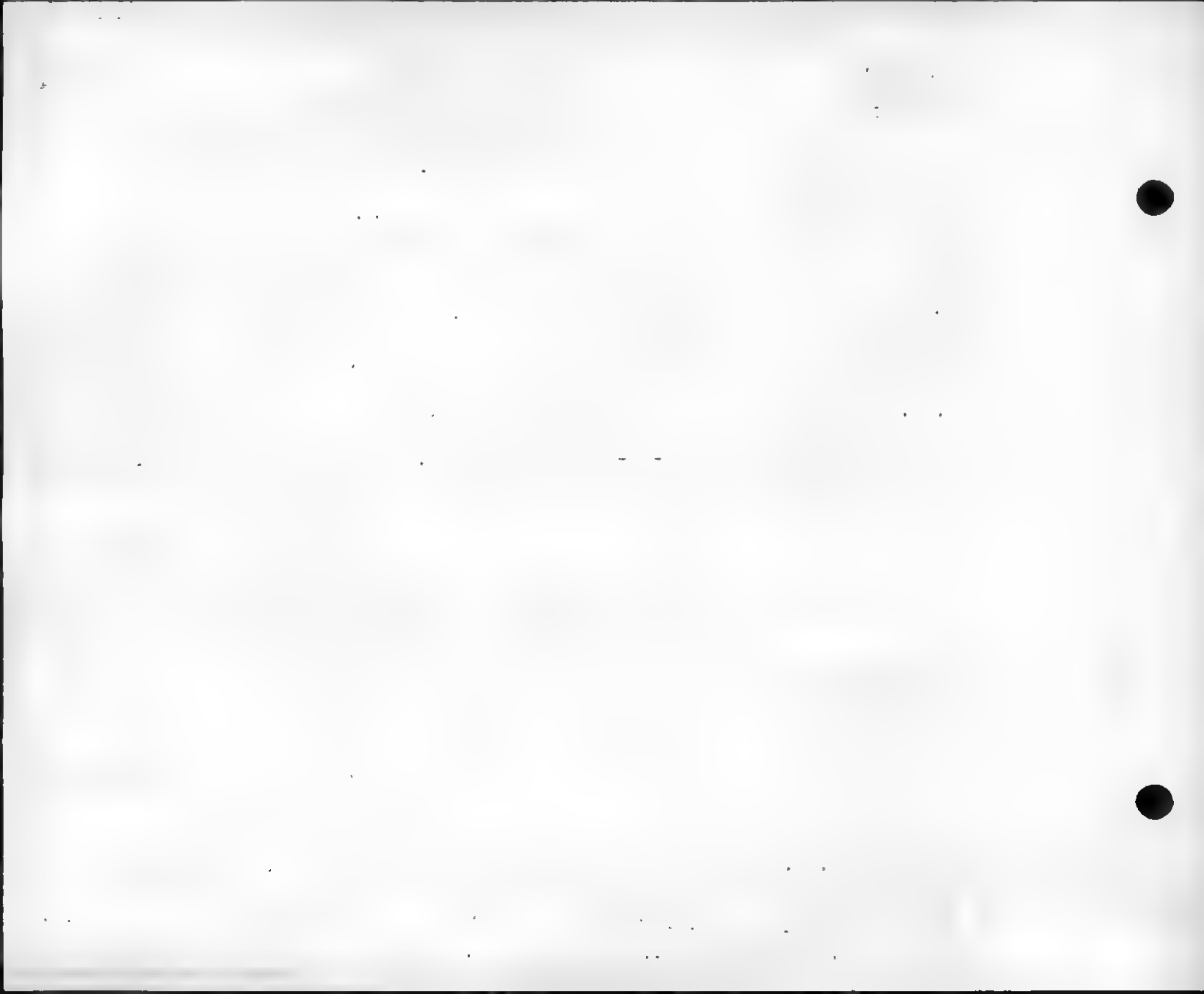
08436

08431

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA	
c. LENGTH OF STAY IN 1b 59 Days		d. STREET ADDRESS 823 Empress Court	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Cutts Last Moore		4. DATE OF DEATH Month June Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 22 1920
9. AGE (in years last birthday) 47 yrs		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. F. Cutts		14. MOTHER'S MAIDEN NAME E. Riles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 049-18-7985	
17. INFORMANT Raymond A. Moore		Address 523 Empress Court, Alexandria, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Infiltrating Carcinoma of Hypopharynx DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 29 , 19 67 , to June 17 , 19 67 , that (I) (we) last saw the deceased alive on June 17 , 19 67 , and that death occurred at 7:55 M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED JUN 21 1967	
22c. PHYSICIAN'S NAME (Type) T. D. Blanton, MD		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 17 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR Demaine Memorial Chapel, 520 S. Washington St., Alexandria, Va.		25a. REC'D BY REGISTRAR JUN 21 1967	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08432

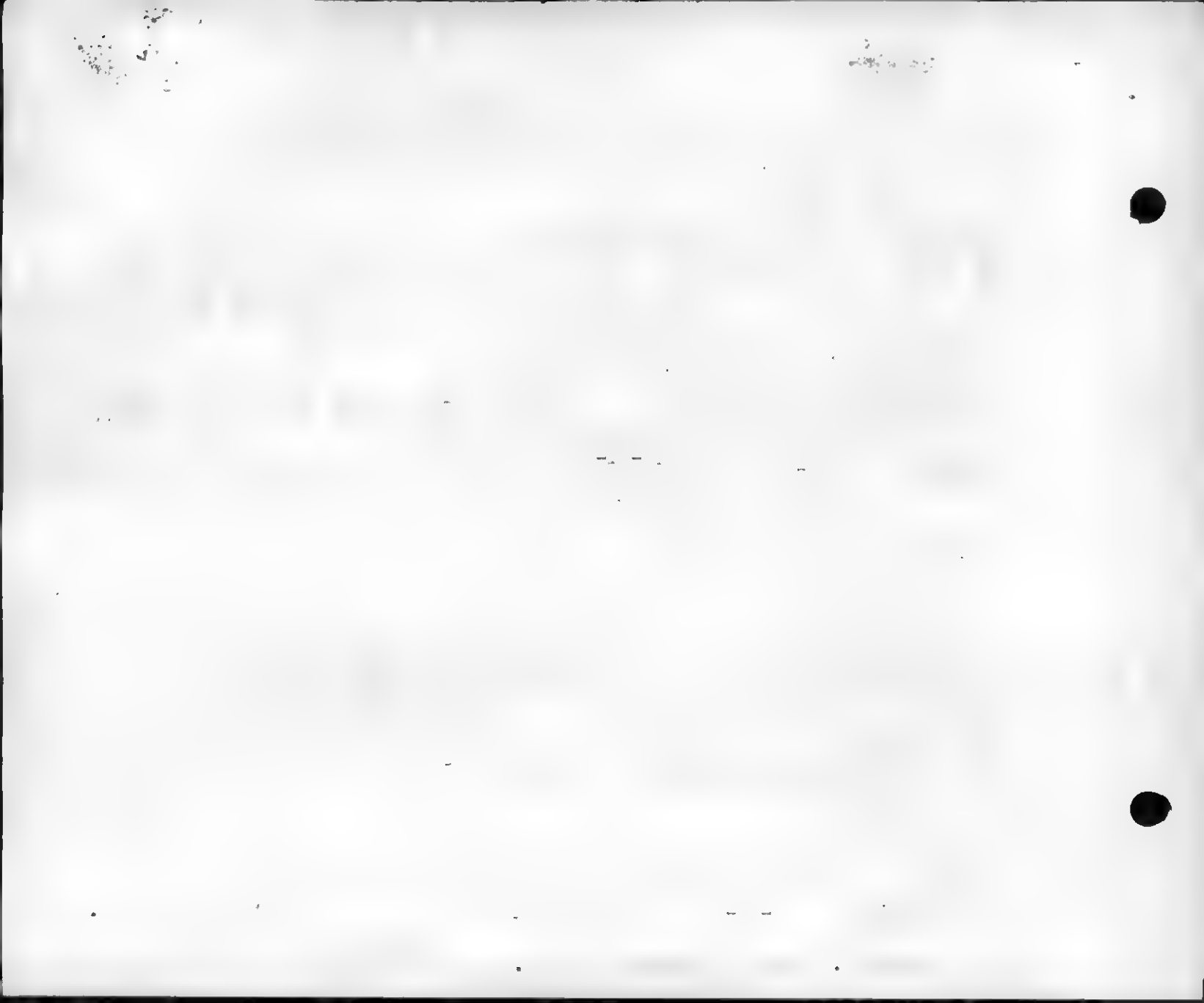
08437

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY in 1b <u>11 hr. 30 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dallas Estie Morris</u>		4 DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-86</u>
9. AGE (In years lost birthday) yrs <u>80</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Milton A. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO <u>219-01-8131</u>	
17. INFORMANT <u>W.S.H. Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO (c) <u>LEFT SIDED CTE & CORONARY ARTERY DISC.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1307m</u>	20f. (City or town) (County) (State) <u>150 PM</u>
21. I certify that (I) (this hospital) attended the deceased from <u>13 June 1967</u> , to <u>13 June 1967</u> , that (I) (we) last saw the deceased alive on <u>13 June 1967</u> , and that death occurred at <u>150 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John L. Ford</u>		22b. DATE SIGNED <u>6-13-67</u>	22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUIS FORD MD</u>
22d. ADDRESS <u>831 UNIVERSITY BLVD. E. SILVER SPRING, MD.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
25a. REGD. BY REGISTRAR <u>JUN 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

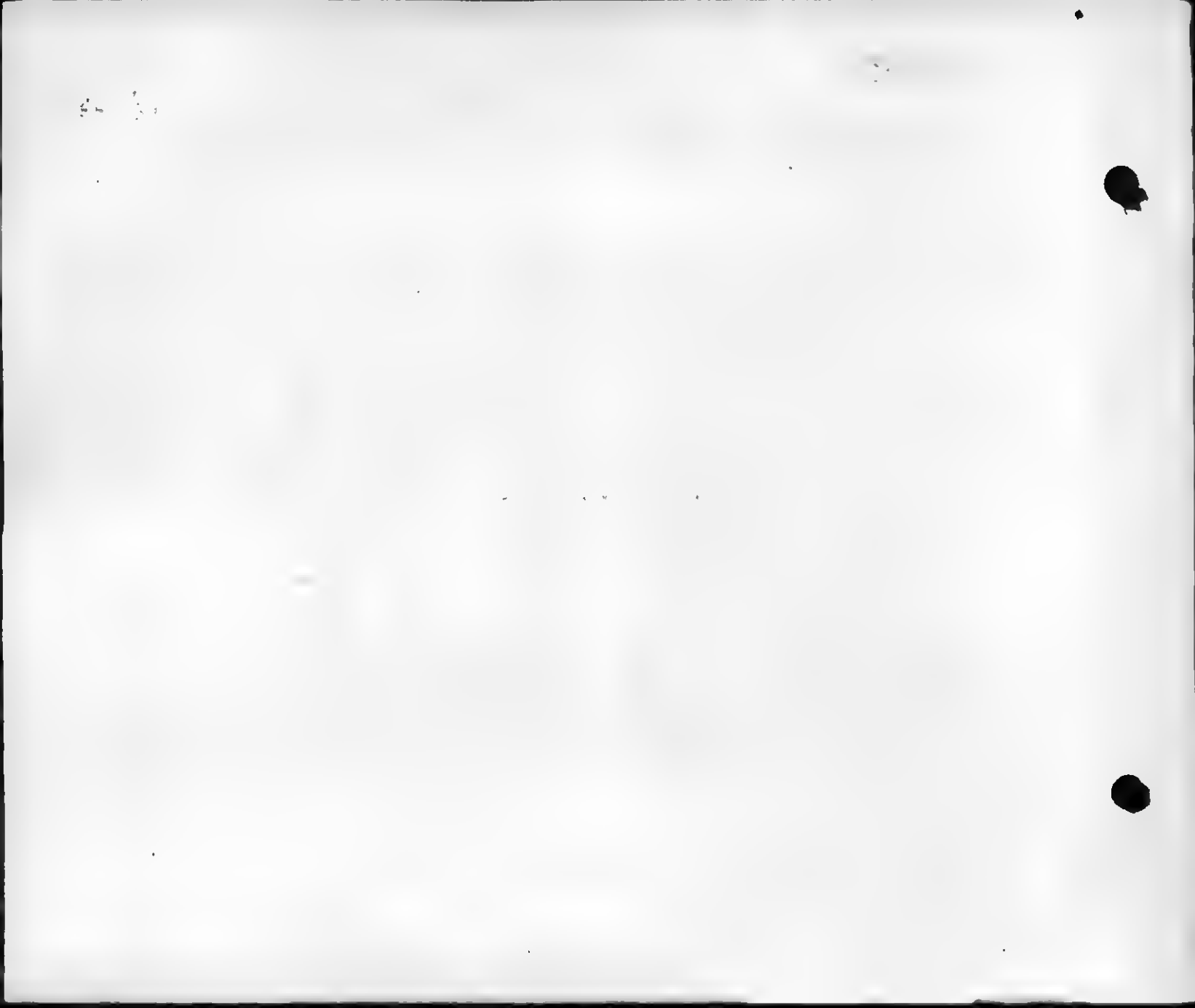


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08433

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8925 BROOKVILLE ROAD				d. STREET ADDRESS 8925 BROOKVILLE ROAD			
3. NAME OF DECEASED (Type or print) First ROBERT Middle HARVEY Last MORSE				4. DATE OF DEATH Month JUNE Day 4 Year 1967			
5. SEX MALE		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/1893	
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARAGE WORK				10b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME ROBERT MORSE I				14. MOTHER'S MAIDEN NAME MARY ARMSTRONG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MRS. EMMA MORSE AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 INFARCTION, ACUTE MYOCARDIAL - septal DUE TO (b) CORONARY ARTERY ATHEROSCLEROSIS DUE TO (c) GENERAL ATHEROSCLEROSIS INCLUDING MESENTERIC ARTERY							INTERVAL BETWEEN ONSET AND DEATH 5 HOURS 5 YEARS 10 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION, CHRONIC							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from 5/19 1966 to JUNE 4 1967 , that (1) (we) last saw the deceased alive on JUNE 4 1967 , and that death occurred at 7:29 AM , from the causes and on the date stated above.							
22a. SIGNATURE James A. Roberts M.D.				22b. DATE 6/4/67			
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS				22d. ADDRESS 8907 GEORGIA AVE SILVER SPRING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Park		23d. LOCATION (City, town, or county) (State) Laurel, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR June 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. The hospital or attending physician, after this certificate has been signed by the attending physician and completely filled in, should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



copy for in Berne. 18 May 67 hospital admission well documented as Myocardial infarct of the heart. Dr. Berne saw patient 14 days after death. Pages 1 and 2 of the funeral director's report should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08433		CERTIFICATE OF DEATH				08434			
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>					d. STREET ADDRESS <u>2330 Glenmont Circle</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Abraham Moser</u>					4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 67</u>				
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/1885</u>		9 AGE (In years last birthday) <u>82</u> yrs	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weight master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marlow Coal Co.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>XXXXXX Wash., D. C.</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13 FATHER'S NAME <u>Joseph Moser</u>					14. MOTHER'S MAIDEN NAME <u>Fannie Breslan</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Joseph Moser</u> Address <u>14113 Chelmsford Road Rockville, Maryland</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arter Thrombosis</u> DUE TO (c) <u>Cerebrovascular sclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ - 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> , 19 <u>67</u> , to <u>6/20</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>14 June 1967</u> , and that death occurred at <u>8:15 AM</u> , from causes and on the date stated above									
22a SIGNATURE <u>Merton L. White</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>20 June 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Merton L. White</u>					22d. ADDRESS <u>9911 Georges Ave Silver Spring, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>June 23, 1967</u>		<u>Parklawn Cemetery</u>		<u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Paul M. Smith</u> ADDRESS <u>434 Georgia Avenue Silver Spring, Md.</u> <u>Warner L. Pumphrey, Inc.</u>					25a REC'D BY REGISTRAR <u>JUN 26 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

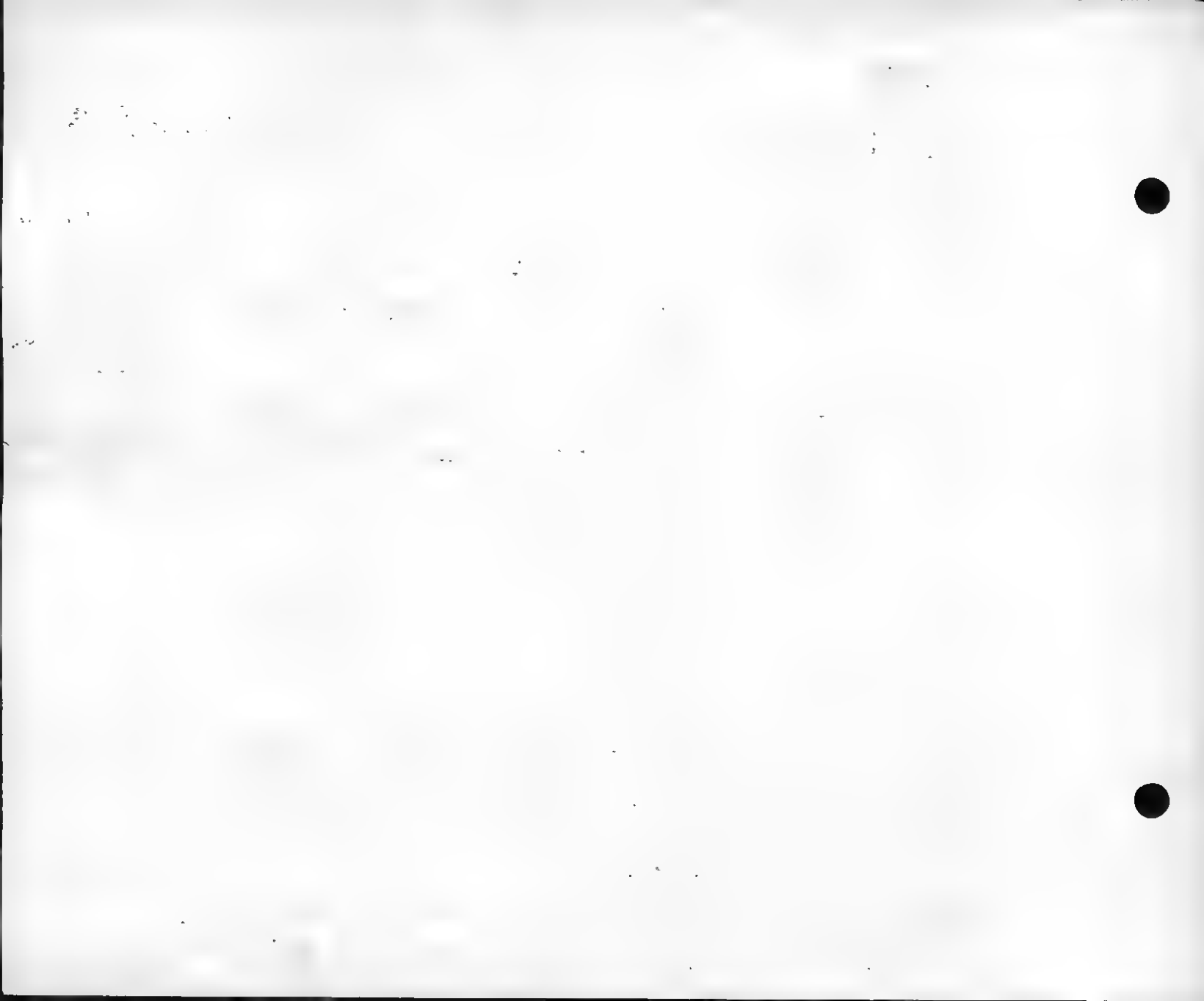
FOR STATE HEALTH DEPT:

08440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08435

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyatt</u>	
c. LENGTH OF STAY in 1b <u>3 days</u>		d. STREET ADDRESS <u>1409 Langley Way #102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HATTIE</u>		4 DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>73</u> 93 73 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (State or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George Burgess</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Bartlett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>213-54-9513</u>	
17 INFORMANT <u>Hosp. record</u>		Address <u>1545 N. Faulkland La. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull with left temporal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>subdural hematoma</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased fell from stretcher in Emergency Room.</u>	
20c TIME OF INJURY Month, Day, Year <u>7:30</u> Hour <u>am</u> <u>6-4</u> 19 <u>67</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f (City or town) (County) (State) <u>Takoma Park Montg. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden A. Neap, M.D.</u>		22. DATE SIGNED <u>JUNE 7, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN A. NEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>June 10, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d LOCATION (City or town, County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Glen Carter</u>		25a REC'D BY REG. STR. <u>JUN 12 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>
<u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		<u>434 Georgia Avenue</u>	



38441

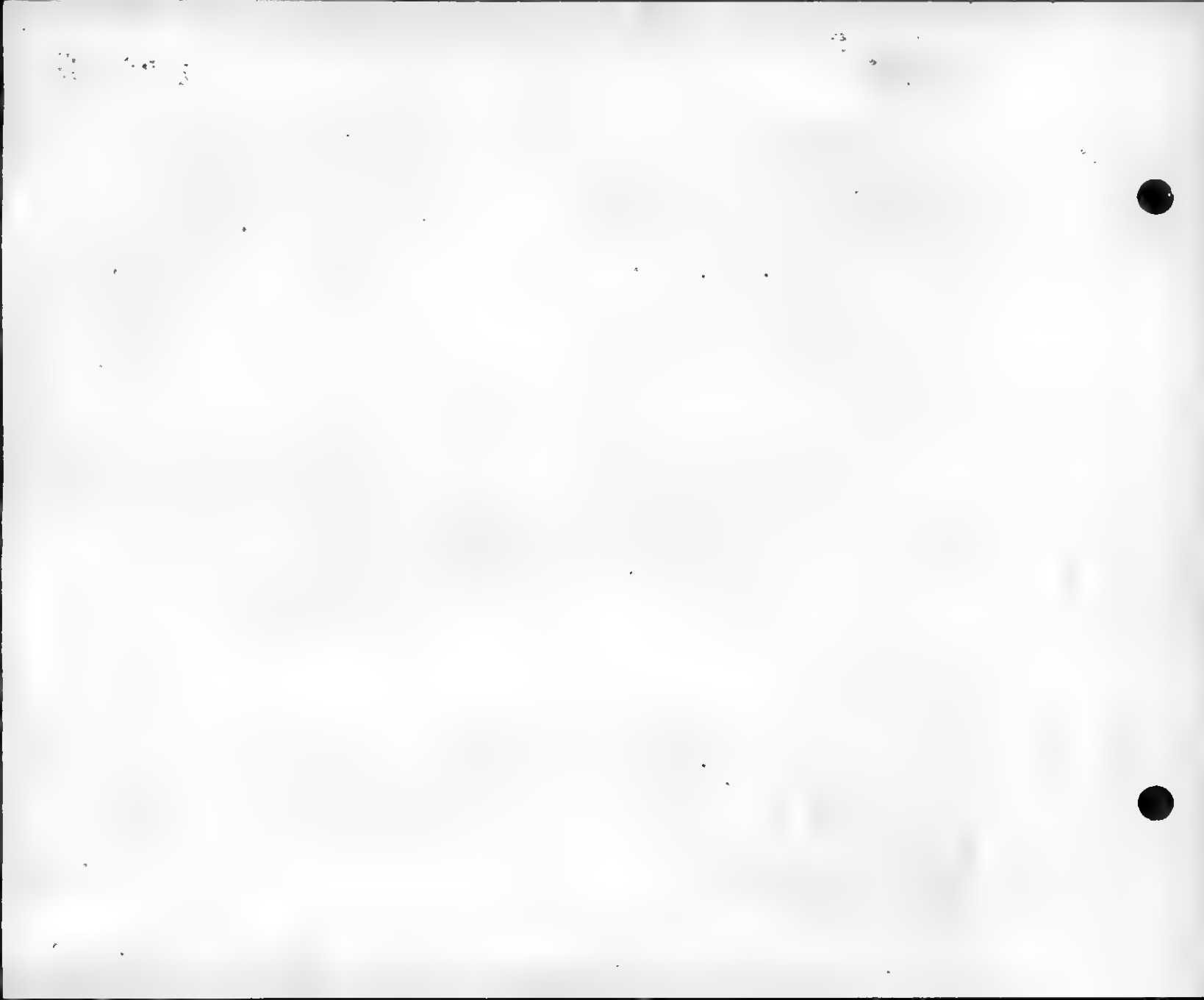
CERTIFICATE OF DEATH

08436

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 12021 Viers Mill Rd.	
3. NAME OF DECEASED (Type or print) Willard S. North		4. DATE OF DEATH Month June Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-97
9. AGE (In years, last birthday) 69 YRS		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker & Realator		10b. KIND OF BUSINESS OR INDUSTRY Realty	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William North		14. MOTHER'S MAIDEN NAME Laura McConaughy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 177-14-2863	
17. INFORMANT 9da North		Address 12021 Viers Mill Road, Wheaton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Calcific Aortic Stenosis DUE TO (c) 42/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 14 mos 48 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/6/67 , 19 66 , to 6/9/67 , 19 67 , that (I) (we) last saw the deceased alive on 6/9/67 , 19 67 , and that death occurred at 7:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Robert C. Macon		22b. DATE SIGNED 6/9/67	
22c. PHYSICIAN'S NAME (Type) Robert C. Macon		22d. ADDRESS 809 Viers Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Miami Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Miami, Florida
24. FUNERAL DIRECTOR C. Glen Carter		25a. REC'D BY REGISTRAR JUN 14 1967	
ADDRESS 18434 Georgia Avenue, Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

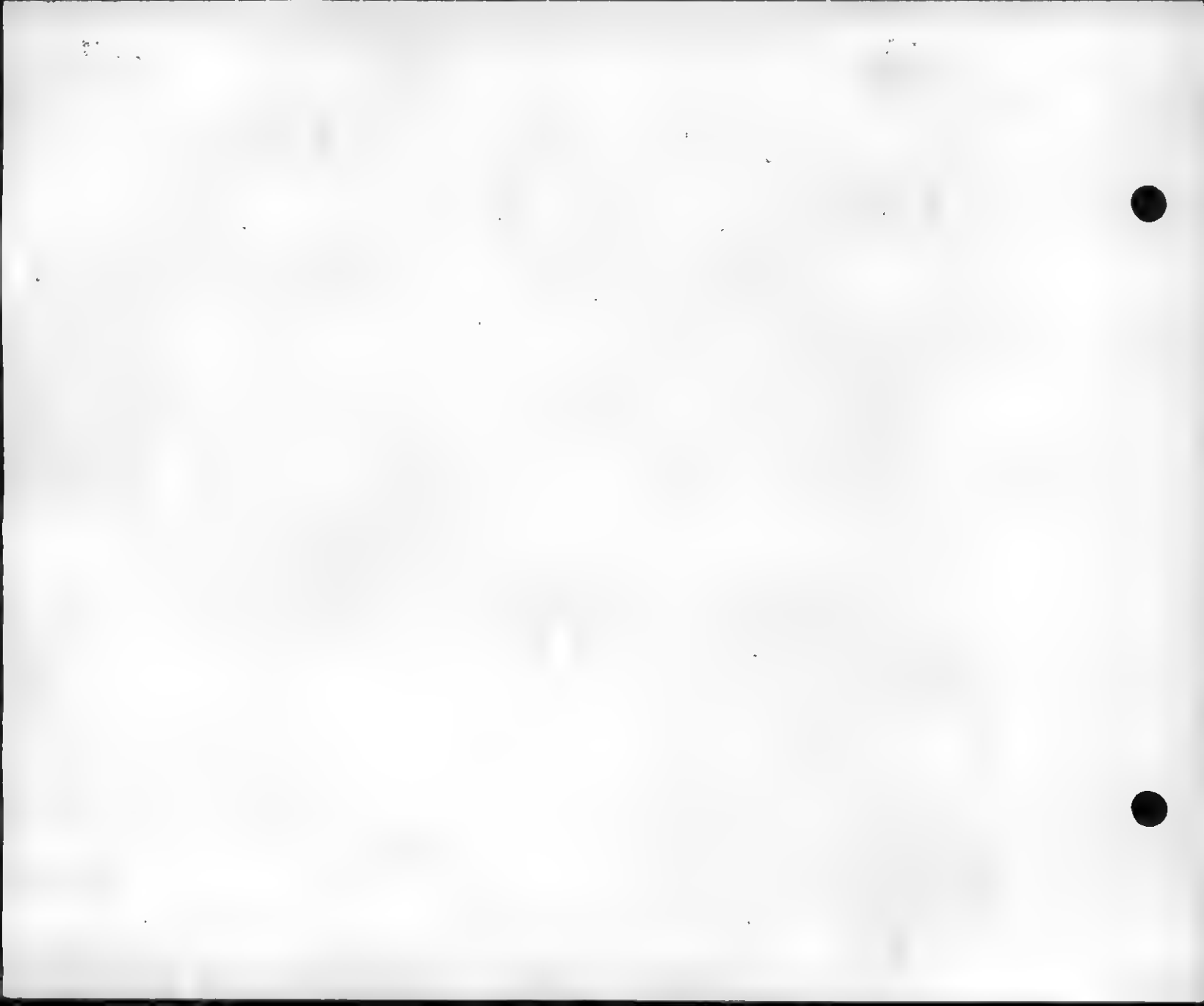
08442

08437

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>1669 Columbia Rd N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Augusta</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-3-83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward B. O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Grace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET OF DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Blinding cerebral aneurysm.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>6-6</u> , 19 <u>67</u> , to <u>6-15</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6-15</u> , 19 <u>67</u> , and that death occurred at <u>12:25</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel T. Harbottle</u>		22b. DATE SIGNED <u>6-15-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>June 17, 1967</u>	<u>St. Marys Cemetery</u>	<u>Alexandria Va.</u>
24. FUNERAL DIRECTOR <u>John H. Mainie, Alexandria, Va.</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal at any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

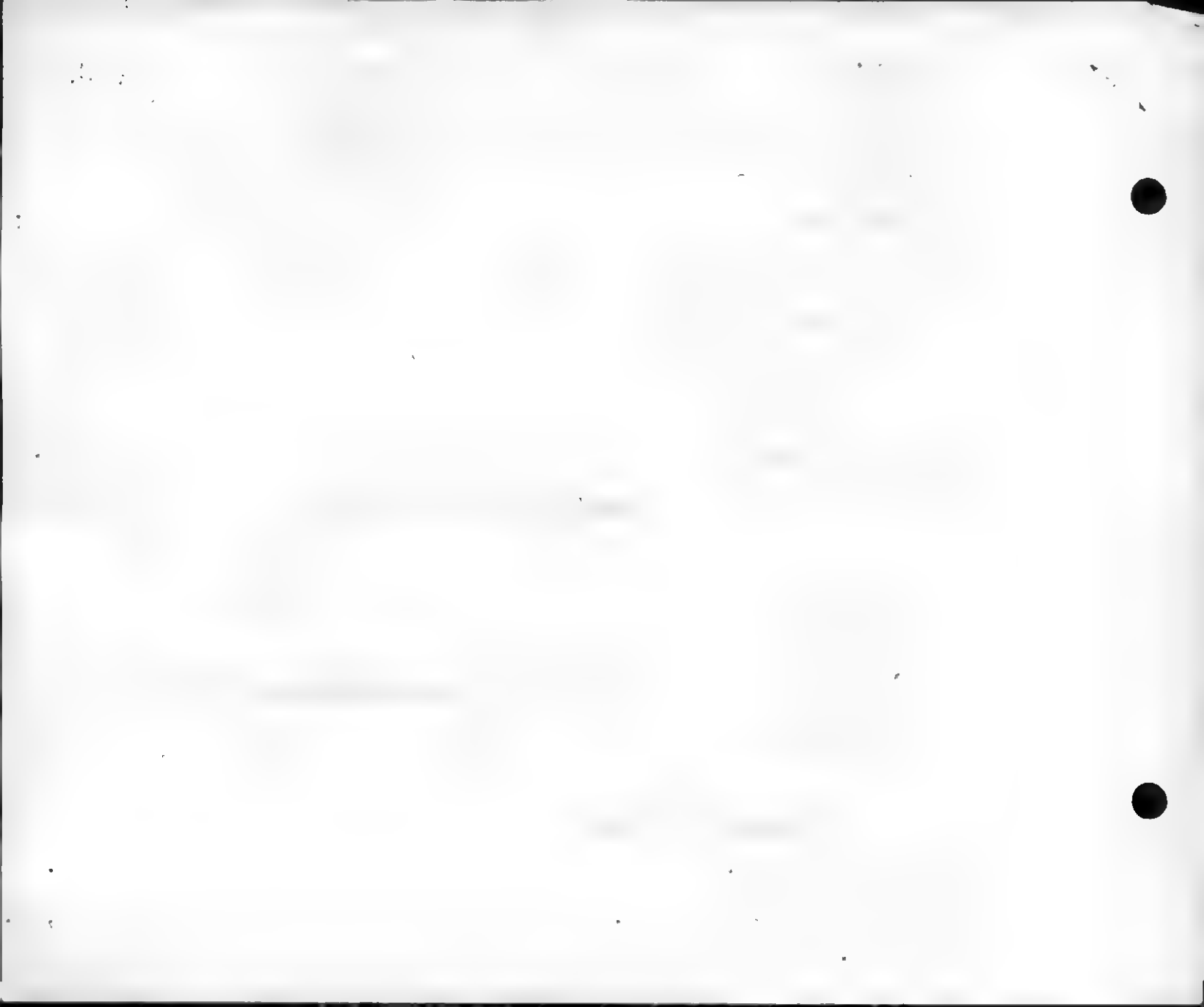
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08443

08438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cedar Lane</u>		d. STREET ADDRESS <u>4402 Edgefield Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Melvin O'Callaghan</u>		e. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typewriter repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash D C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin O'Callaghan, Jr</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Utz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>	
17. INFORMANT <u>Father</u>		Address <u>Edwin O'Callaghan, Jr, Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Head Injury Severe</u> 10.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Lost control of car while driving + struck Utility Pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:50 PM 6/2 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Kensington Mont. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/3/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

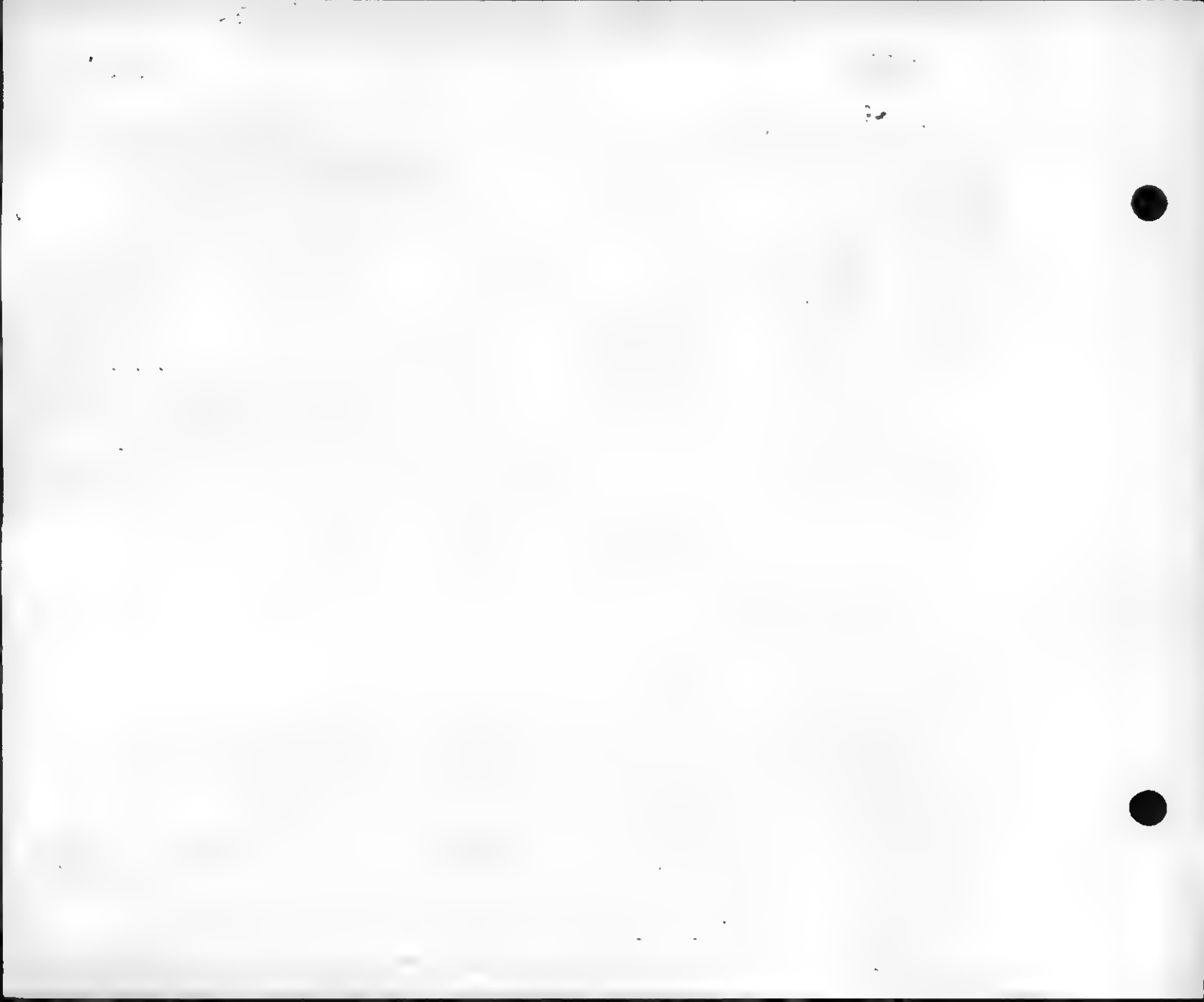
08444

CERTIFICATE OF DEATH

08439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery Co. 4th Dist</u>				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c LENGTH OF STAY IN 1b <u>5 mos</u>				d STREET ADDRESS <u>4410 Oglethorpe St. Hyattsville, Md.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Columbia Villa Conv. Home</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Marjorie</u> Last <u>Osman</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-12</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>		11. IF UNDER 24 HRS Hours <u>11</u> Min <u>05</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hamburg Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry E. Geary</u>				14. MOTHER'S MAIDEN NAME <u>Frances Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO <u>Yes</u>		17. INFORMANT <u>Edward Geary</u> Address <u>4410 Oglethorpe St. Hyattsville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOBLASTOMA</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PROBABLE BRONCHOPNEUMONIA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <u>(the hospital)</u> attended the deceased from <u>JUNE</u> , 1966 to <u>6 JUNE</u> , 1967, that (1) <u>(was)</u> last saw the deceased alive on <u>5 JUNE</u> 1967, and that death occurred at <u>12:45 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR. MD</u>				22d. ADDRESS <u>831 UNIVERSITY BLVD. E. SILVER SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>June 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hamburg, Penna.</u>	
24. FUNERAL DIRECTOR <u>Clark E. Warner</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film #G249 52-167 pc

08445

CERTIFICATE OF DEATH

08440

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>42 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6821 Winnepeg Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>JAMES</u> Last <u>OSTEN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/12</u>	9. AGE (In years last birthday) <u>55</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min <u> </u>	12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SOUTH DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES J. OSTEN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BEMEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1943-1946</u>		16. SOCIAL SECURITY NO <u>485-05-9924</u>		17. INFORMANT (WIFE) <u>MRS E. J. OSTEN</u> Address <u>6821 WINNEPEG RD. BETHESDA, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, cerebral, spontaneous</u> <u>436X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>POLYARTERITIS NODOSA</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN DEATH AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>6-3</u> , 1967, that (I) (we) last saw the deceased alive on <u>6-3</u> , 1967, and that death occurred on <u>6/3</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Herbert L. Tanenbaum</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT L. TANENBAUM</u>				22d. ADDRESS <u>4400 Conn Ave NW WASH DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>6/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEE CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>LEE F. H. 300 9th St. N.E., WASH., DC.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08446

08441

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY N.H.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
f. STREET ADDRESS 1316 NEW HAMPSHIRE, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CECELIA Middle ELIZABETH Last OTIS		4 DATE OF DEATH Month JUNE Day 10 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 7, 1886
9 AGE (In years last birthday) 80 yrs		10 IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. - TEACHER		10b. KIND OF BUSINESS OR IND. STRY TEACHING	
11. BIRTHPLACE (County & State, or foreign country) ST. PAUL, MINN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR G. OTIS		14. MOTHER'S MAIDEN NAME CECELIA WHITACRE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT ELIZ. DAVIES, 6624 RANNOCH RD, BETH, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glioblastoma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/28/67 to 6/10/67 , that (I) (we) saw the deceased alive on 6/10/67 , 19 — , and that death occurred at 6:30 PM from causes and on the date stated above.			
22a. SIGNATURE Henry C. Scruggs M.D.		22b. DATE SIGNED 6/10/67	22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS M.D.
22d. ADDRESS 5413 Cedar Lane Bethesda Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 6/10/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.	23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.
24. FUNERAL DIRECTOR JOS. GAWLERIS SONS, 5130 WIS. AVE, N.W., WASH, DC.		25a. REC'D BY REGISTRAR JUN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08442

FOR STATE
HEALTH DEPT.

08447

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Pennsylvania b COUNTY ✓	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 24 hrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e STREET ADDRESS 1311 Fanshawe St	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Alice Middle none Last Oxman		4 DATE OF DEATH Month 6 - Day 9 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-1-XXXX1894
9 AGE (In years last birthday) 73 yrs		F UNDER 1 YEAR Months 7 Days 13 Hours 13 Min 13	
10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Wilkesbarre, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Barnett Cohen		14 MOTHER'S MAIDEN NAME Sarah Cohen	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes give war or dates of service) no		16 SOC. SEC. SECURITY NO 714-09-9001	
17 INFORMANT Benjamin Oxman (husband)		Address 1311 Fanshawe St. Phila. Pa.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4301 DUE TO (b) Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) years		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/10/67	
		Address (Street city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Buried		23b DATE THEREOF JUNE 17, 1967	
23c NAME OF CEMETERY OR CREMATORY MONTICLORE CEMETERY		23d LOCATION (City or Town) (County) (State) MONTGOMERY COUNTY PG.	
24 FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 3501-14th St. NW, Wash. DC.	
25 REC'D BY REGISTRAR JUN 14 1967		26 REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

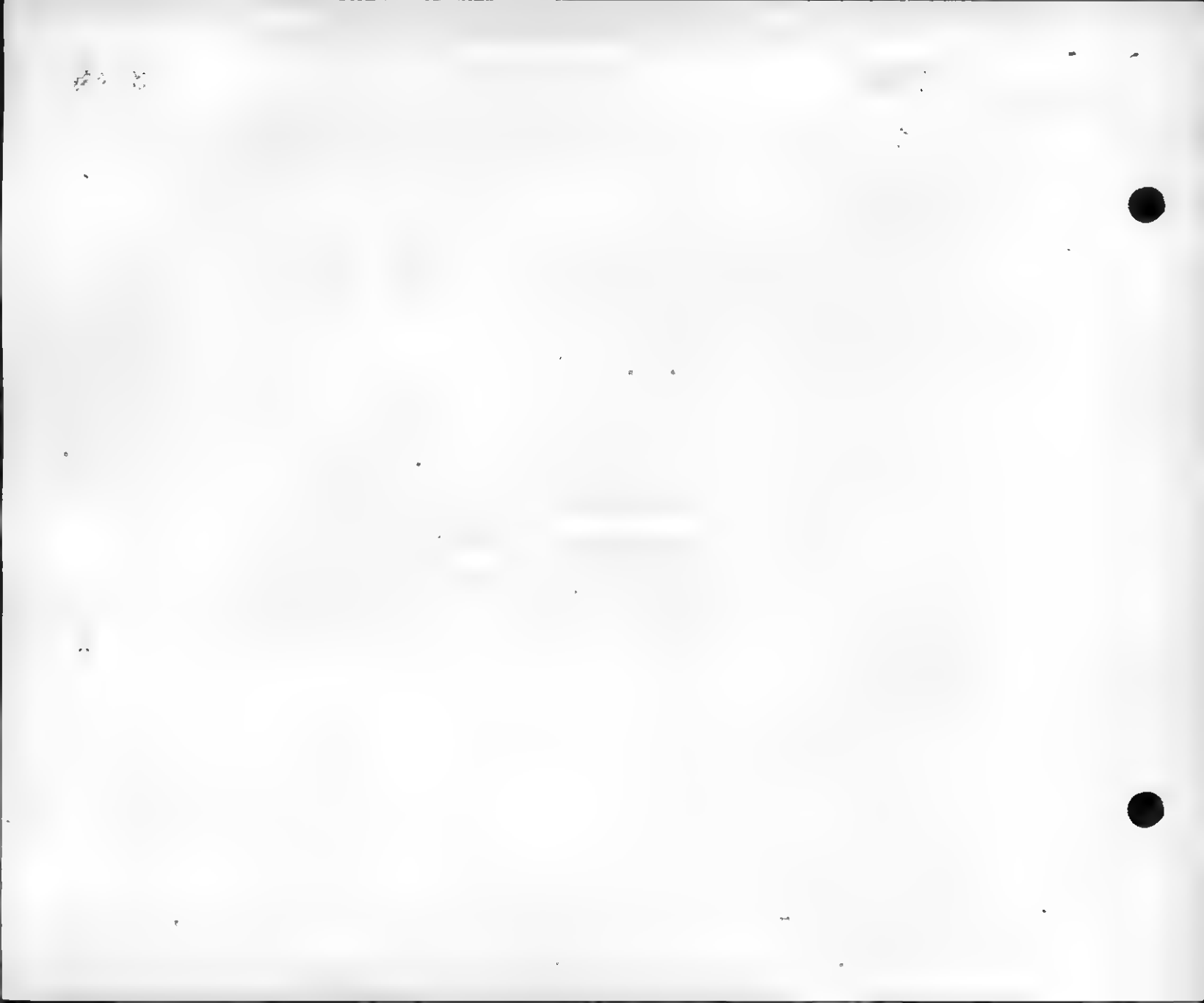
08443

78448

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8706 OLD GEORGETOWN RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John EMORY Pollock</u>		4. DATE OF DEATH Month Day Year <u>June 21 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/92</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D C</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George F Pollock</u>	
14. MOTHER'S MAIDEN NAME <u>Cora Lee Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>217-44-4829</u>		17. INFORMANT <u>Wife</u> <u>Grace A. Pollock</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ruptured esophageal varices</u> (c) <u>cirrhosis, Laennec's</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 14, 1967</u> to <u>June 20, 1967</u> . That (I) (we) lost s/he the deceased alive on <u>June 20, 1967</u> and that death occurred at <u>2:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Vicente de Guzman</u>		22b. DATE SIGNED <u>June 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vicente de GUZMAN</u>		22d. ADDRESS <u>1234 19 NW Wash DC</u>	
23a. BURIAL CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18&21 film 390 7-11 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08444

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		d. STREET ADDRESS 10003 THORNWOOD RD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10003 THORNWOOD RD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last DOROTHY POSTEL				4 DATE OF DEATH Month Day Year JUNE 24 1967			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/12/11	9 AGE (in years lost birthday) 55 yrs	10 UNDER 1 YEAR Months Days Hours Min.		11 UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE F. DEISER				14 MOTHER'S MAIDEN NAME NELLIE J. JENKINS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address Mrs. EDITH W. JENKINS - 705 - 18th St. N.W. D.C.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Metamorphosis of liver, acute- 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Chronic and acute alcoholism DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John B. Ball M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/26/67 Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6-30-67		23c. NAME OF CEMETERY OR CREMATORY CREMATORY		23d. LOCATION (City or Town) (County) (State) BLITLAND M.D.	
24 FUNERAL DIRECTOR ROBERT H. HUMPHREY 7557 W. SCENIC AVE.				25a. REC'D BY REGISTRAR JUL 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film 403,000 (1/1/67) DC

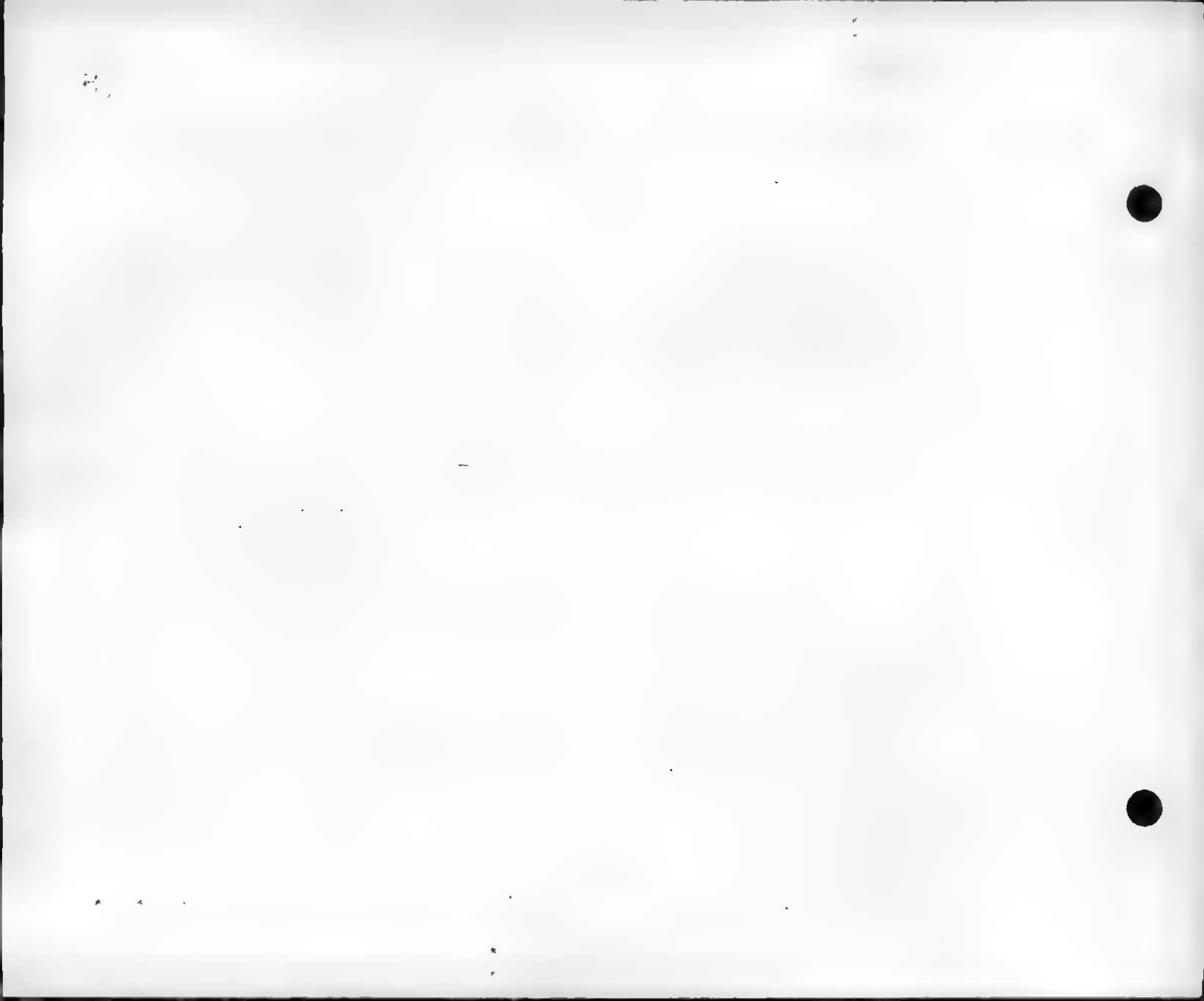
08450

CERTIFICATE OF DEATH

08445

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3510 Salem Way Bethesda Md</u>				d. STREET ADDRESS <u>3510 Salem Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Loretta</u> Last <u>Power</u>				4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 10 1905</u>		9. AGE (In years last birthday) <u>61</u> Yrs	10. IF UNDER 1 YEAR Months <u>12</u> Days <u>14</u> Hours <u>14</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M Power</u>				14. MOTHER'S MAIDEN NAME <u>Loretta C Gray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-46-2054</u>		17. INFORMANT <u>James E Power</u> Address <u>414 Prospect St Seattle Wash 98109</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous carcinoma of Pharynx</u> DUE TO (b) <u>with neck node Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>6 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>148X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/24 1967</u> to <u>6/24 1967</u> , that (I) (we) last saw the deceased alive on <u>6/23 1967</u> and that death occurred at <u>7 A.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>Frederick Y. Denn</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick Y. Denn</u>				22d. ADDRESS <u>10400 Connecticut Ave., Kensington Md</u>			
23a. BURIAL, CREMATION, REINTERMENT <u>BURIAL</u>		23b. DATE THEREOF <u>6-28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>				25a. REC'D BY REGISTRAR <u>7557 Wisc Ave. Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

08451

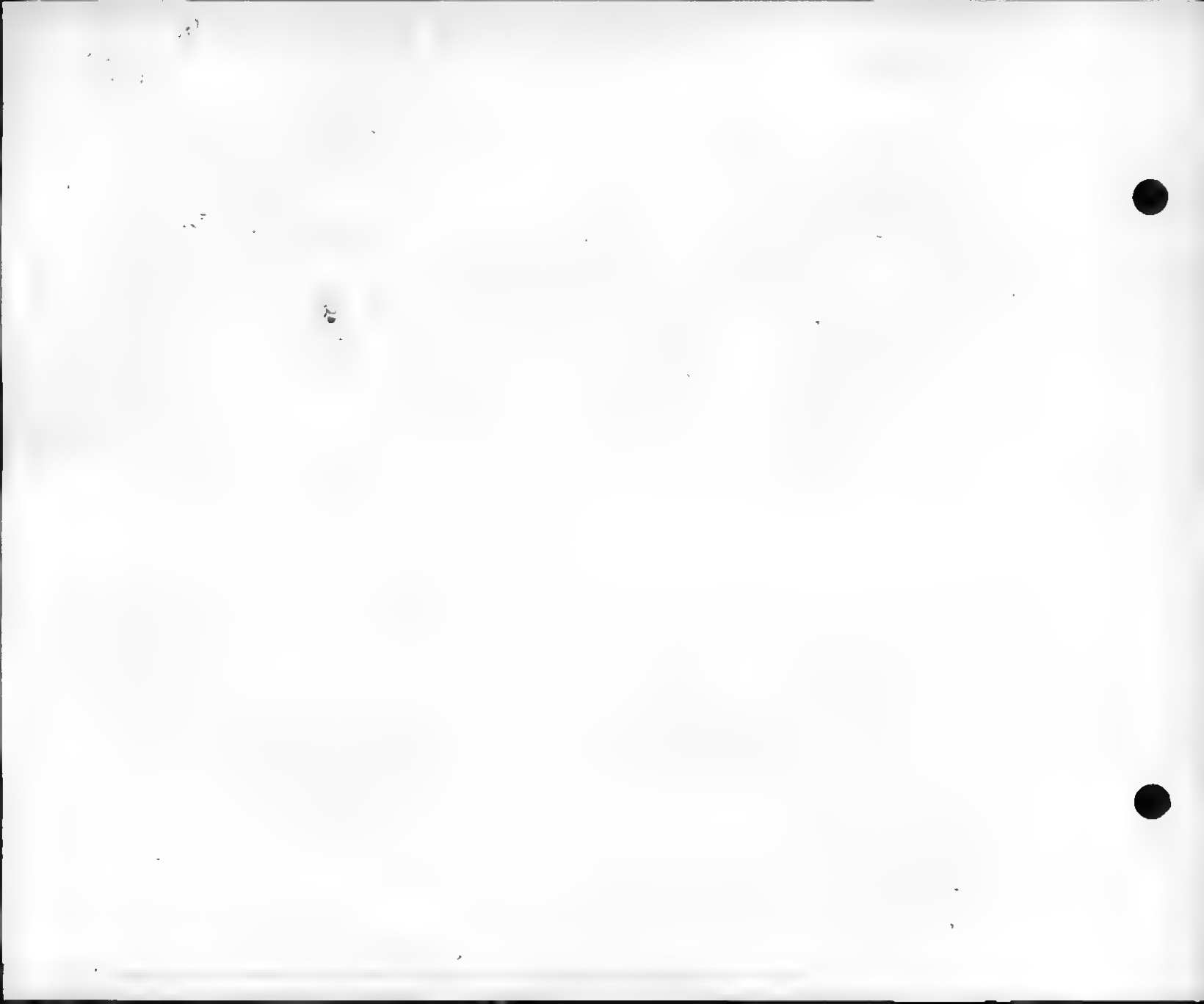
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08446

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (if outside corporate limits, write R.R. and give nearest town) <u>Takoma Park</u> c LENGTH OF STAY IN 1b <u>Silver Spring</u>			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (if outside corporate limits, write R.R. and give nearest town) <u>Silver Spring</u> d STREET ADDRESS <u>209 Southampton Dr</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hospital</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
NAME OF DECEASED (Type or print) <u>Harry B. Rappaport</u>			4 DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-4-25-1923</u>	9 AGE (In years lost birthday) <u>44</u> yrs	10 IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>67</u> Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b KIND OF BUSINESS OR INDUSTRY <u>BookStore</u>	11 BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>SAMUEL RAPPAPORT</u>			14 MOTHER'S MAIDEN NAME <u>JENNIE WEISS</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>579-28-2443</u>	17 INFORMANT <u>JOSEPH RAPPAPORT</u> Address <u>7664 MARLE AVE TAKOMA PARK, MD</u>		
8 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4301 Acute myocardial dis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic myocardial dis.</u> DUE TO (c) <u>Coronary atherosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u> <u>Yrs.</u> <u>Yrs.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>None</u>					19 WA AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f ((city or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>7-11-1967</u>	
EXAMINER'S NAME Type <u>[Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street city town or county)					
23a BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>6-12-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>GED. WASH. Cem.</u>	23d LOCATION (City or town) <u>HATTSVILLE</u>	(County) <u>PG.</u>	(State) <u>MD</u>
24 FUNERAL DIRECTOR <u>CONDOR 66 FUNERAL HOME</u>		ADDRESS <u>4217 9th St. N.W.</u>		25 REG'D BY REGISTRAR <u>JUN 14 1967</u>	26 REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08452

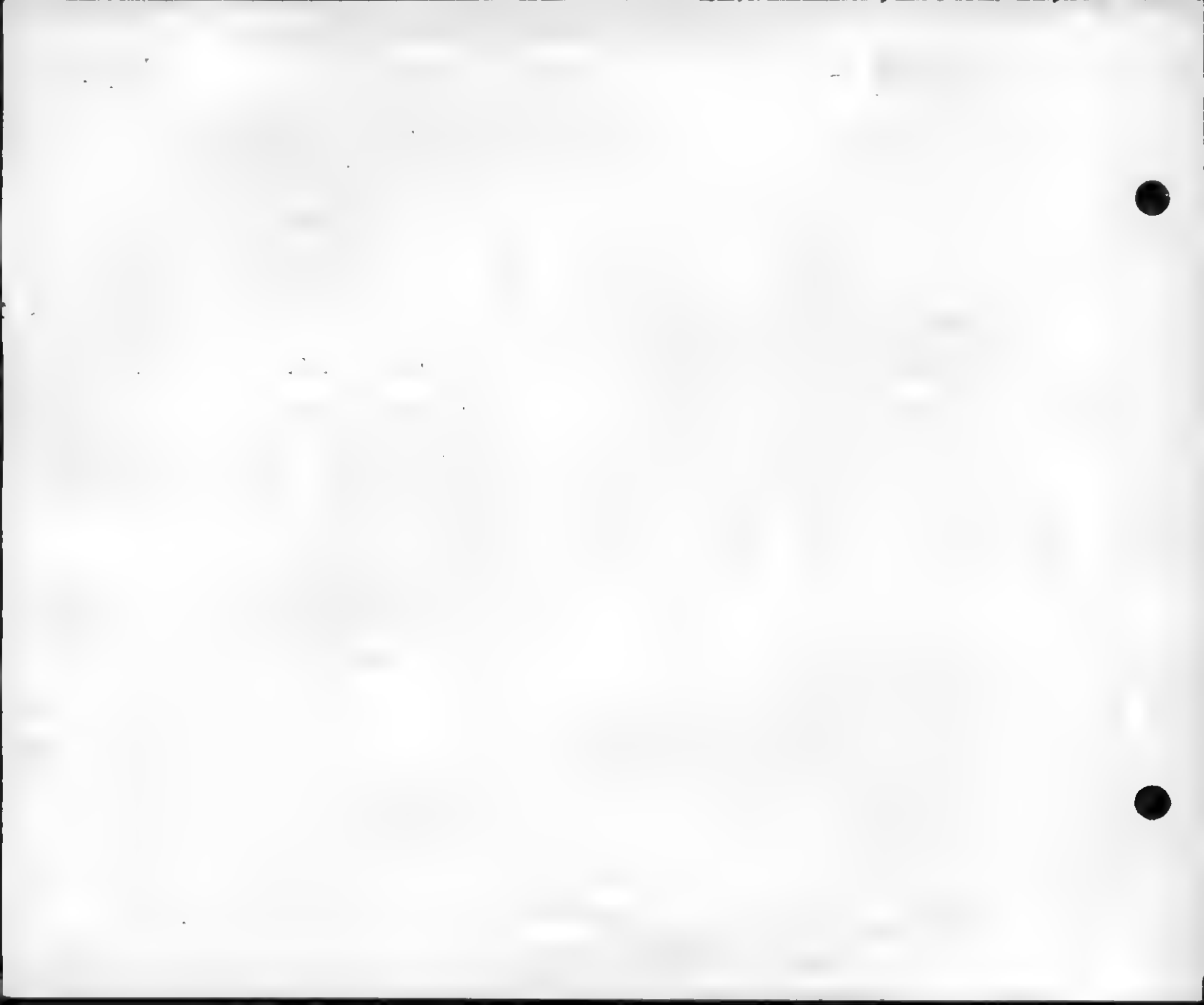
CERTIFICATE OF DEATH

08447

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>5 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1805 Innis Road</u>				d. STREET ADDRESS <u>1805 Innis Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Traynor</u> Middle <u>Ray</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 7, 1864</u>	
9. AGE (In years last birthday) <u>103</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
12. CITY, STATE, AND COUNTRY OF BIRTH <u>U.S.A.</u>				13. FATHER'S NAME <u>William Traynor</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Jane Champion</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Laura J. Renshaw</u> Address <u>1805 Innis Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Serum</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from <u>June, 1967</u> to <u>June, 1967</u> , that (I) (we) last saw the deceased alive on <u>6-24</u> 19 <u>67</u> , and that death occurred at <u>6:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 W. BLVD E. SILVER SP. MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

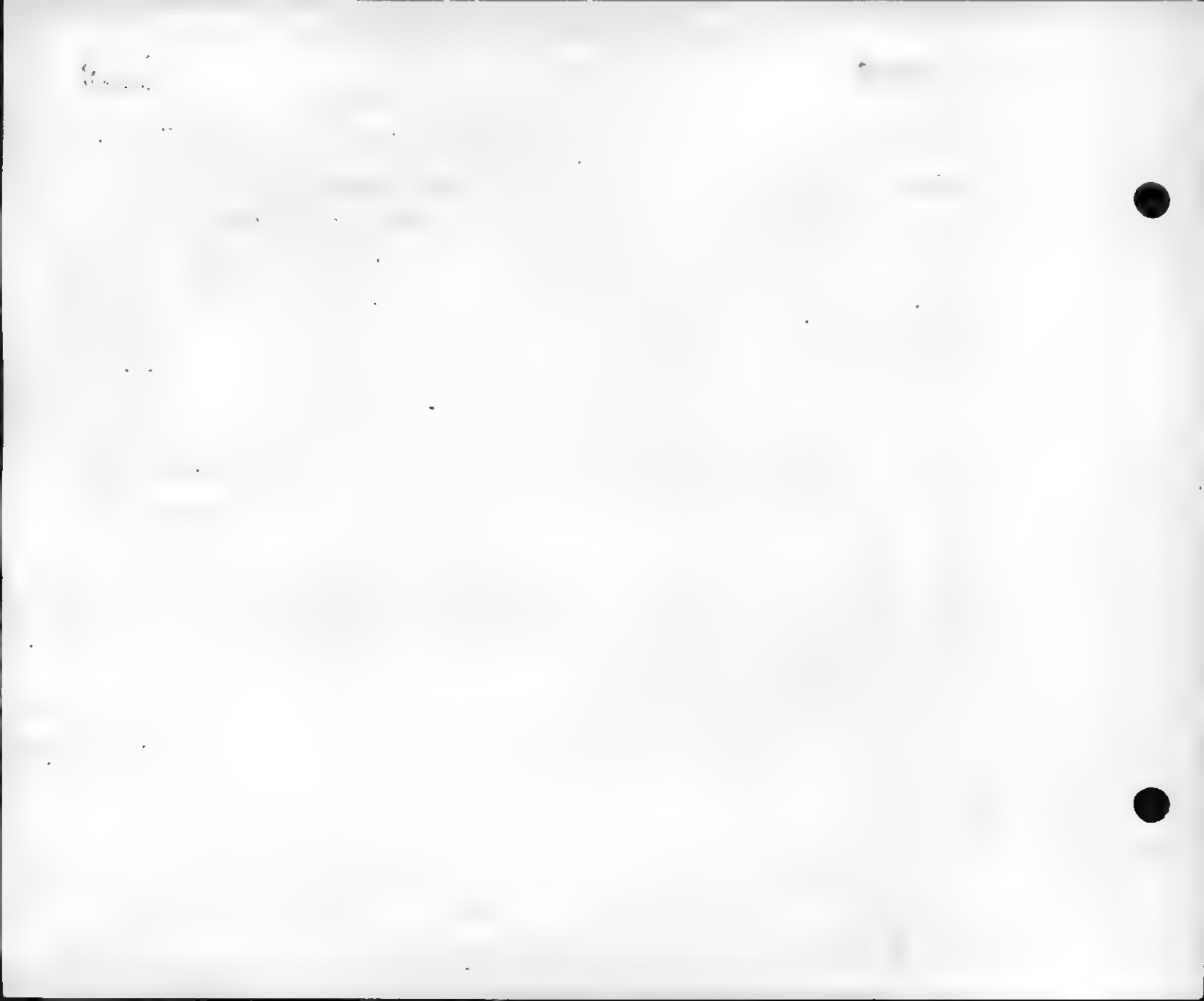
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08453

CERTIFICATE OF DEATH

08448

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY in b <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Catherine</u>				4 DATE OF DEATH Month Day Year <u>June 26 19 67</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1889</u>	9 AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Schirmer</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Nagengast</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-30-7227-8</u>		17. INFORMANT Address <u>George Raymond 313 Lexington Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>See Part I</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1967</u> , to <u>June 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 26, 1967</u> , and that death occurred at <u>10:00</u> M. from causes on and on the date stated above.							
22a. SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 29 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Warner E. Pumphrey, Inc.</u>				22d. ADDRESS <u>18434 Georgia Avenue Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

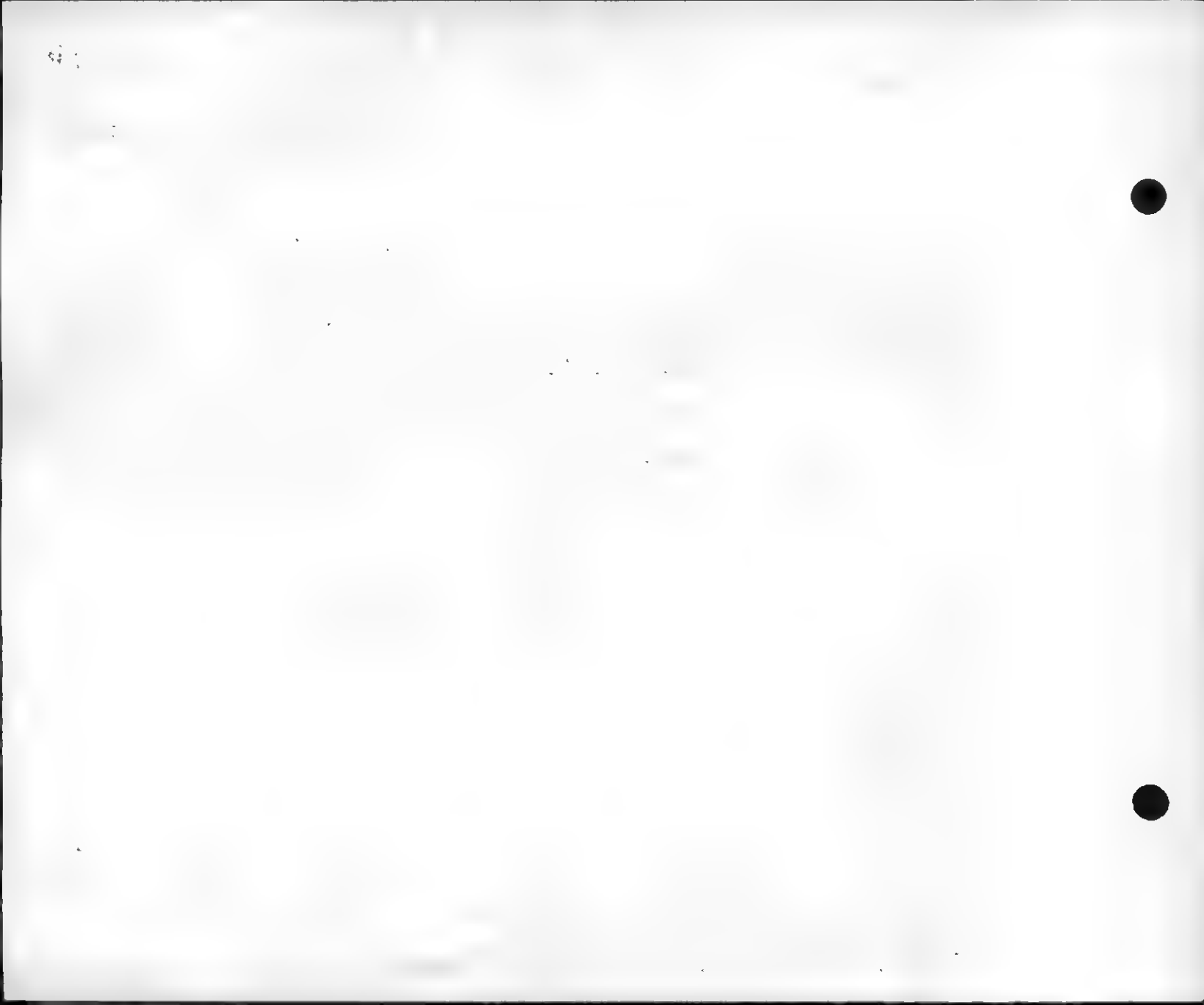
08449

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>3224 Geiger St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARGARET REEVE</u>		4. DATE OF DEATH Month Day Year <u>JUNE 20 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7, 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal Mfg. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Jackson Center, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. ages.</u>	
13. FATHER'S NAME <u>ORLAND ROGERS - Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Cecile Linson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>295-22-6102</u>	
17. INFORMANT <u>Claude L. Reeve</u>		Address <u>3224 Geiger Street Kensington, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concentric Hypertrophy of Heart with</u> + DJE TO <u>Cardiac Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden K. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN K. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, City, Town, or County)	
22. DATE SIGNED <u>6/20/1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>June 23, 1967</u>	<u>Parklawn Cemetery</u>	<u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter, 8434 Georgia Avenue, Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>MIN 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

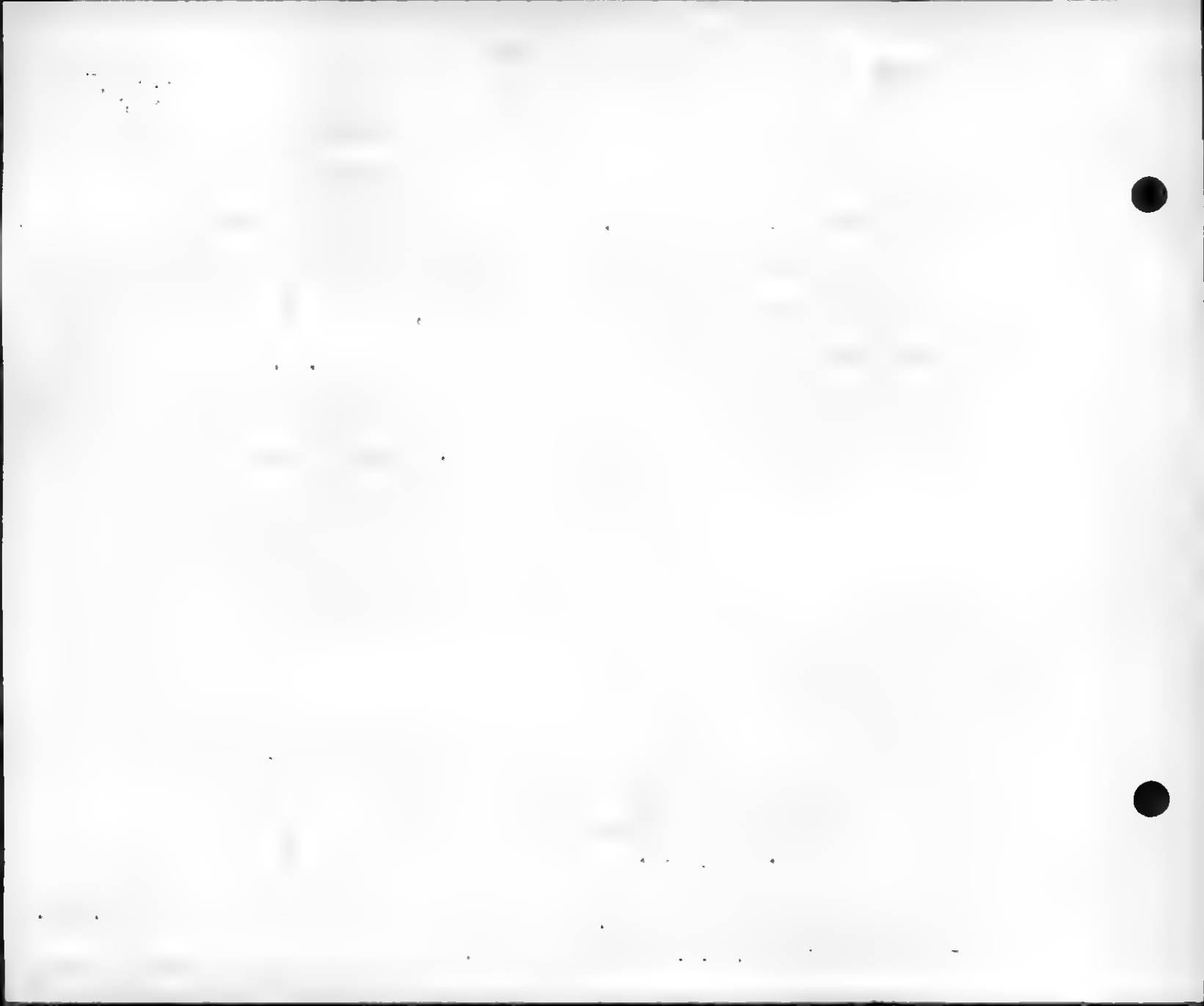
08450

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RURAL				c. LENGTH OF STAY IN IS DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, BETHESDA, MD.				d. STREET ADDRESS 5315 MC KINLEY STREET			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET RHODES RICHARDSON				4. DATE OF DEATH Month Day Year JUNE 6 19 67			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 2, 1905	
9. AGE (In years last birthday) 62 61 yrs		10. US.A. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME FRANK ROLAND RHODES				14. MOTHER'S MAIDEN NAME EMMA PATRICK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO NONE		17. INFORMANT JOHN H. RICHARDSON Address SAME AS 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending/ Broncho pneumonia left lower lobe 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 weeks Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home farm factory street office bldg. etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN G. BALL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street city town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
Cremation 6-8-1967		6-8-1967		Ft. Lincoln Crematory		Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S NAME (Type) Joseph Gawler & Sons				25. SET BY REGISTRAR			
5130 Wisconsin Ave. N.W., Washington, D.C.				25c. REGISTRAR'S SIGNATURE			
				DATE JUN 12 1967 Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

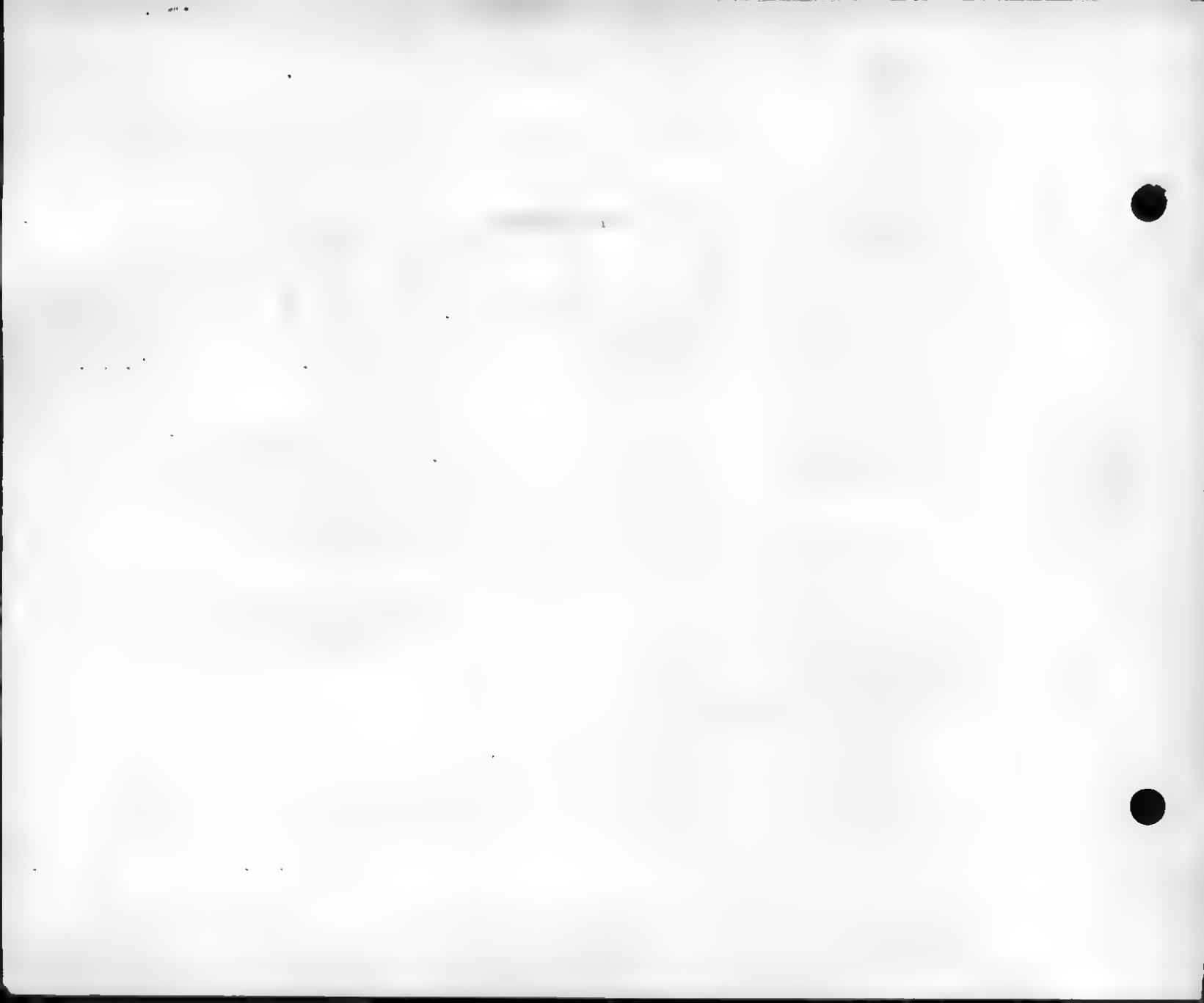
08456

08451

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home Potomac Valley Nursing and Convalescent</u>				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>7009 Georgia Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>Willis</u> Last <u>RILEY</u>			4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 67</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7, 1894</u>	9. AGE (In years last birthday) <u>73</u> yrs	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Terminal Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			
13. FATHER'S NAME <u>Peter Jackson Riley</u>			14. MOTHER'S MAIDEN NAME <u>Willie Turner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>718-14-9172</u>		17. INFORMANT <u>Ruth K. Riley</u> Address <u>7009 Georgia Street Chevy Chase, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>1992</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Indefinite</u> (c) <u>Indefinite</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis with Rt Hemiplegia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>			
20f. (City or town) (County) (State) <input type="checkbox"/>		21. I certify that (1) (this hospital) attended the deceased from <u>1965</u>, 19<u>65</u>, to <u>6/5</u>, 19<u>67</u>, that (1) (we) last saw the deceased alive on <u>5/31</u>, 19<u>67</u>, and that death occurred at <u>6:55 AM</u>, from causes and on the date stated above.					
22a. SIGNATURE <u>Alexander C. Leonardo</u>			22b. DATE SIGNED <u>6/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Alexander C. Leonardo</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>Glen Carter</u> Address <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc.</u> Silver Spring, Md.					
25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

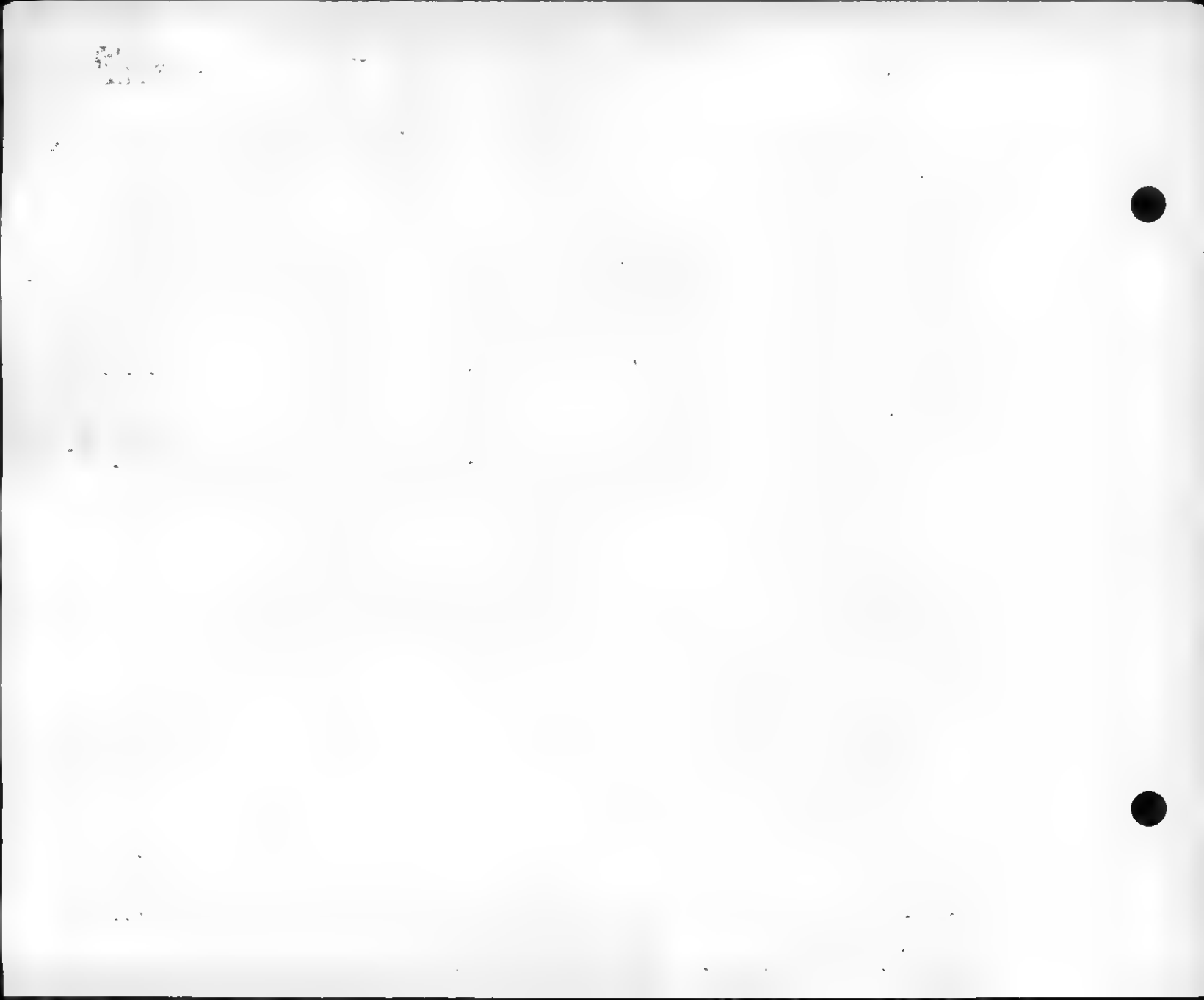
CERTIFICATE OF DEATH

08452

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>11 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nurs. Home 12325 N. HAMP AVE</u>		d. STREET ADDRESS <u>14808 Carrollton Rd</u>	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Potter</u> Last <u>Ripley</u>		4 DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Realtor</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Amsterdam New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Ernest Ripley</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16 SOCIAL SECURITY NO <u>579-01-2231A</u>	
17 INFORMANT <u>Mrs. Merle Ripley</u>		Address <u>14808 Carrollton Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4710</u> DUE TO <u>Branchopneumonia</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> min <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>67</u> , to <u>6-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-29</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>R. H. Sandstrom M.D.</u>		22b DATE SIGNED <u>6-29-67</u>	
22c PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>		22d ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>June 30, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24 FUNERAL DIRECTOR <u>John B. Thomas & Son, Inc. 434 Georgia Avenue Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>DATE JUL 3 1967</u>	25b REGISTRAR'S SIGNATURE <u>William Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08458

08453

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Tree</u> c. LENGTH OF STAY IN 1b <u>46 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sharon Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12728 Gould Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Beatrice Robertson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1967</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Cauc.</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 6 1906</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Statistical Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia Polk County</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wesley Henley</u> 14. MOTHER'S MAIDEN NAME <u>Mary Forsythe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>577-60-2664</u> 17. INFORMANT <u>Virginia P. Patterson</u> Address <u>Rockville, Md. 506 Lintthicum St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2d. 2wk</u> <u>Yes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>6/18/67</u> (County) <u>6/19/67</u> (State) <u>6/19/67</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>6/18/67</u> to <u>6/19/67</u> that (I) (we) last saw the deceased alive on <u>6/19/67</u> and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Sandy Spring, Md.</u>		22b. DATE SIGNED <u>6/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C.H.H. Gow</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u> 23b. DATE THEREOF <u>June 24, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Macon, Georgia</u> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> DATE <u>JUN 22 1967</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified with Med. Examiner in file



FOR STATE
 HEALTH DEPT.

08453

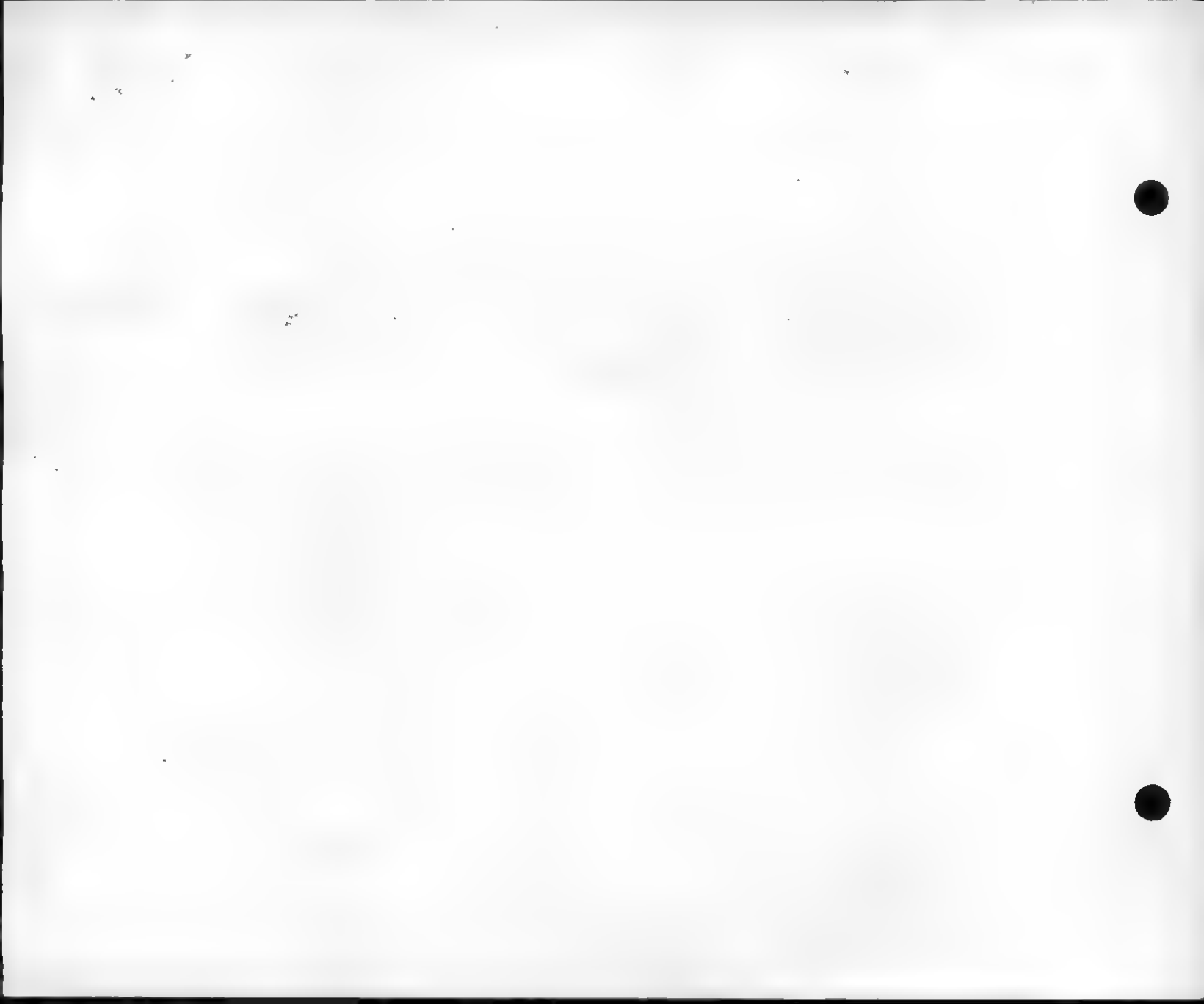
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08454

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>PRINCE GEO.</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>				c LENGTH OF STAY IN TB <u>D.O.A.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>				a STREET ADDRESS <u>2211 AMHERST RD.</u>			
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>(NM)</u> Last <u>ROGERS</u>				4 DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1967</u>			
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>10-27-17</u>	
9 AGE (In years and birthday) <u>49</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, then if retired) <u>German Technician</u>				10b KIND OF BUSINESS OR INDUSTRY <u>General Truck</u>			
11 BIRTHPLACE (State or foreign country) <u>South Carolina</u>				12 CITIZEN OF WHAT COUNTRY? <u> </u>			
13 FATHER'S NAME <u>SIDNEY ROGERS</u>				14 MOTHER'S MAIDEN NAME <u> </u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>				16 SOCIAL SECURITY NO <u> </u>		17 INFORMANT <u>MRS KAREN ROGERS (Wife)</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple skull fractures with</u> DUE TO (b) <u>intracranial hemorrhage due to fall</u> DUE TO (c) <u> </u> Cand tans, fany, whch gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased fell down stairs at home</u>			
20c TIME OF INJURY Month Day Year <u>645</u> Hour <u>pm</u> <u>6-3</u> 19 <u>67</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home farm factory street office bldg etc) <u>Home</u>	
20f (City or town) (County) (State) <u>Lewisdale Pr. Geo. Md.</u>							
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED <u>June 4, 1967</u>							
23a BURIAL CREMATION REMOVAL Specify <u>Burial</u>		23b DATE THEREOF <u>June 6-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		23d LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>	
24 FUNERAL DIRECTOR <u>Arthur Walters</u>				25 ADDRESS <u>254 Carroll St</u>		25a REC'D BY REGISTRAR DATE <u>JUN 6 1967</u>	
				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

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6M 1/66

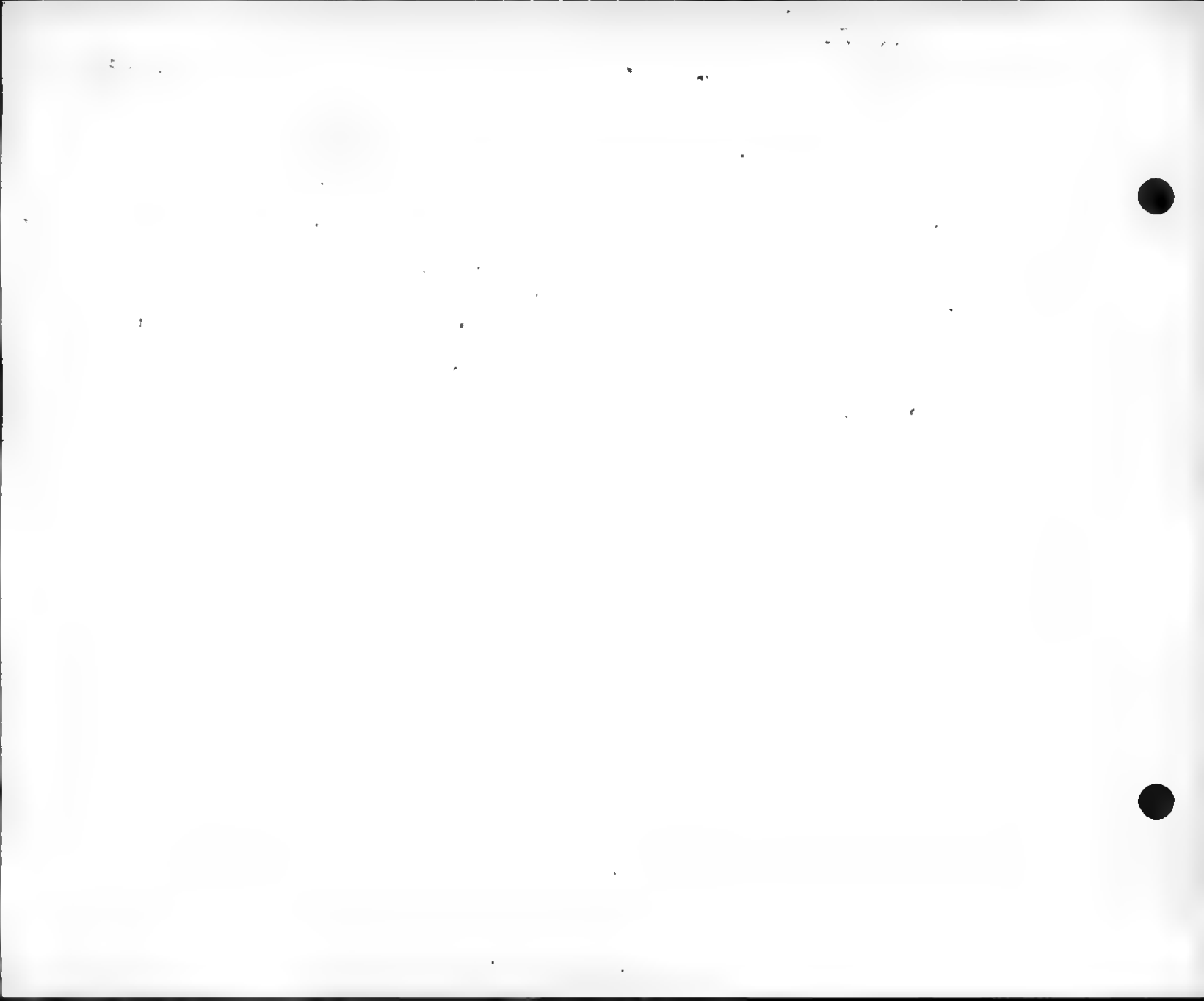
Items 18-21 Film 390 7-18 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08455

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in an institution or residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>444 58th Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Lori T. Rogers</u>		4 DATE OF DEATH <u>June 4 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/21/66</u>
9 AGE (In years last birthday) <u>8 mos.</u>		10 IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u></u> Mins. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>David Rogers</u>		14 MOTHER'S MAIDEN NAME <u>Marlene C. ROSENBERG</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>-</u>	
17 INFORMANT <u>HOSP RECORDS</u>		Address <u>6</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Cerebral Contusion</u> DUE TO <u>and</u> (b) <u>Subarachnoid Hemorrhage</u> DUE TO <u>due to fall</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Deceased infant fell from sofa to floor.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30</u> hour a.m. <u>6-1</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home farm factory street office bldg. etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bladensburg</u> <u>PrGeo</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>June 4, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY-6 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAE CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>FAIRVIEW - N.J.</u>	
24. FUNERAL DIRECTOR <u>B Sangansky & Sons</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1967</u>	
ADDRESS <u>3501-1425 N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

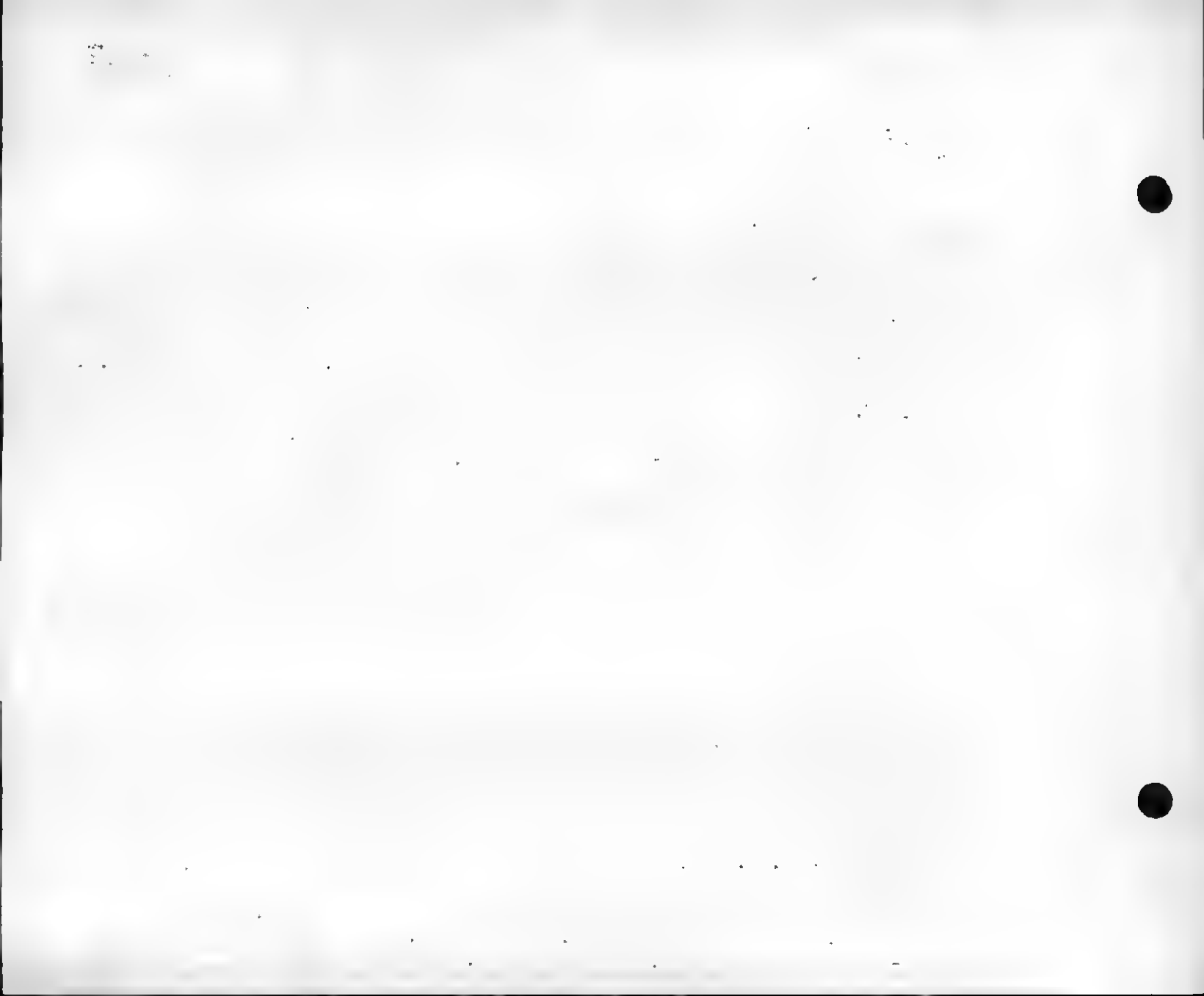
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

084561

08456

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 25 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 4922 Chesterfield Road	
3. NAME OF DECEASED (Type or print) Ruby Ruth Ross		4. DATE OF DEATH Month June Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 April 1912
9. AGE (in years last birthday) yrs. 55		IF UNDER 1 YEAR Months 17 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lampassas, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John D. White		14. MOTHER'S MAIDEN NAME Mary Katherine Hinkle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 455-07-8650	
17. INFORMANT Joe K. Ross		Address 4922 S. Chesterfield Road, Arlington, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 23 May , 19 67 , to 17 June , 19 67 , that (X) (we) lost saw the deceased alive on 17 June , 19 67 , and that death occurred at 10:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>William R. Hix</i>		22b. DATE SIGNED 18 June 1967	
22c. PHYSICIAN'S NAME (Type) ICDR W. R. HIX, MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-21-67	23c. NAME OF CEMETERY OR CREMATORY Bellwood Cemetery	23d. LOCATION (City or Town) (County) (State) Temple, Texas
24. FUNERAL DIRECTOR <i>M. G. Gault</i> Everely-Wheatly Funeral Home, Alexandria, Va.		25. REC'D BY REGISTRAR DAWN 21 1967	
25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



08462

CERTIFICATE OF DEATH

08457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11017 Horde Street</u>	
3 NAME OF DECEASED (Type or print) First <u>Judith</u> Middle <u>E</u> Last <u>Rubin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1929</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9 AGE (In years last birthday) <u>37</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jacob Weinberg</u>		14. MOTHER'S MAIDEN NAME <u>Eva Edlavitch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>218-28-8330</u>	
17 INFORMANT <u>Albert S. Rubin - Same as #2 above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of Breast</u> DUE TO (c) <u>24rs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>6/14</u> , 1967, that (1) (we) last saw the deceased alive on <u>6/13</u> , 1967, and that death occurred at <u>2:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold, B.H. Eig, M.D.</u>		22b. DATE SIGNED <u>6/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold B.H. Eig</u>		22d. ADDRESS <u>8641 Collesville Rd. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Com.</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis Annapundel Md.</u>
24. FUNERAL DIRECTOR: <u>Beverly L. Hopping</u> HOPPING FUNERAL HOME - <u>Annapolis, Maryland</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> DATE <u>JUN 16 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

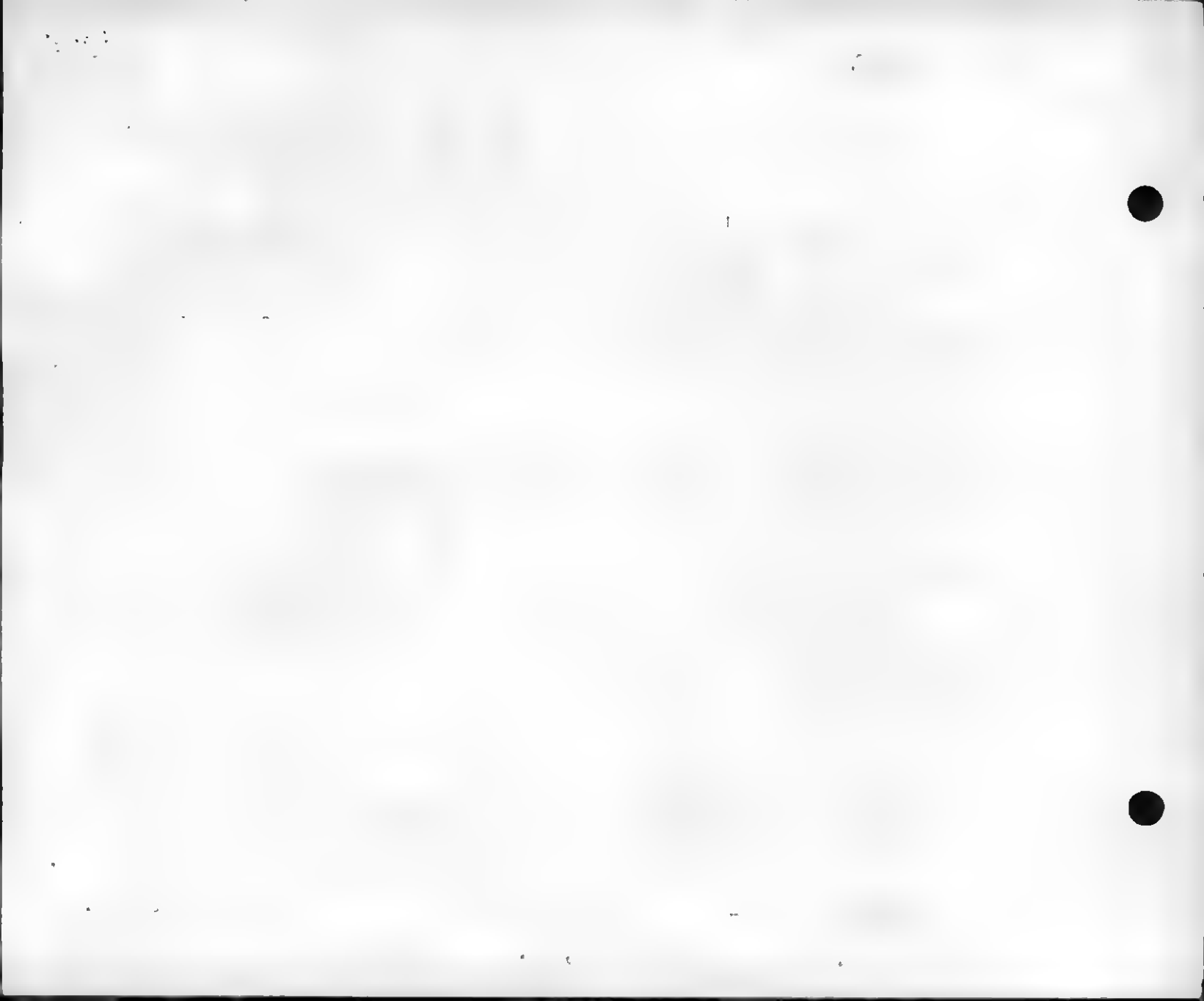
08463

08458

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE (PARENTS ADDRESS) MD. c. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS ROUTE 4	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle -- Last RUSSO		4. DATE OF DEATH Month JUNE Day 17 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1967
9. AGE (in years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months -- Days -- Hours 30 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY, Co., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST JOHN RUSSO, JR.		14. MOTHER'S MAIDEN NAME JOAN MARIE COLLINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT ---		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/17, 1967 , to 6/17, 1967 , that (I) (we) last saw the deceased alive on 6/17, 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE L.S. Batman M.D.		22b. DATE SIGNED 6-17-67	
22c. PHYSICIAN'S NAME (Type) DR. LOUISA S. BATMAN, M. D.		22d. ADDRESS PROFESSIONAL BUILDING, DAMASCUS, MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-18-67	23c. NAME OF CEMETERY OR CREMATORY Laytonsville	23d. LOCATION (City or Town) (County) (State) Laytonsville Md.
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR JUN 22 1967	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ready event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

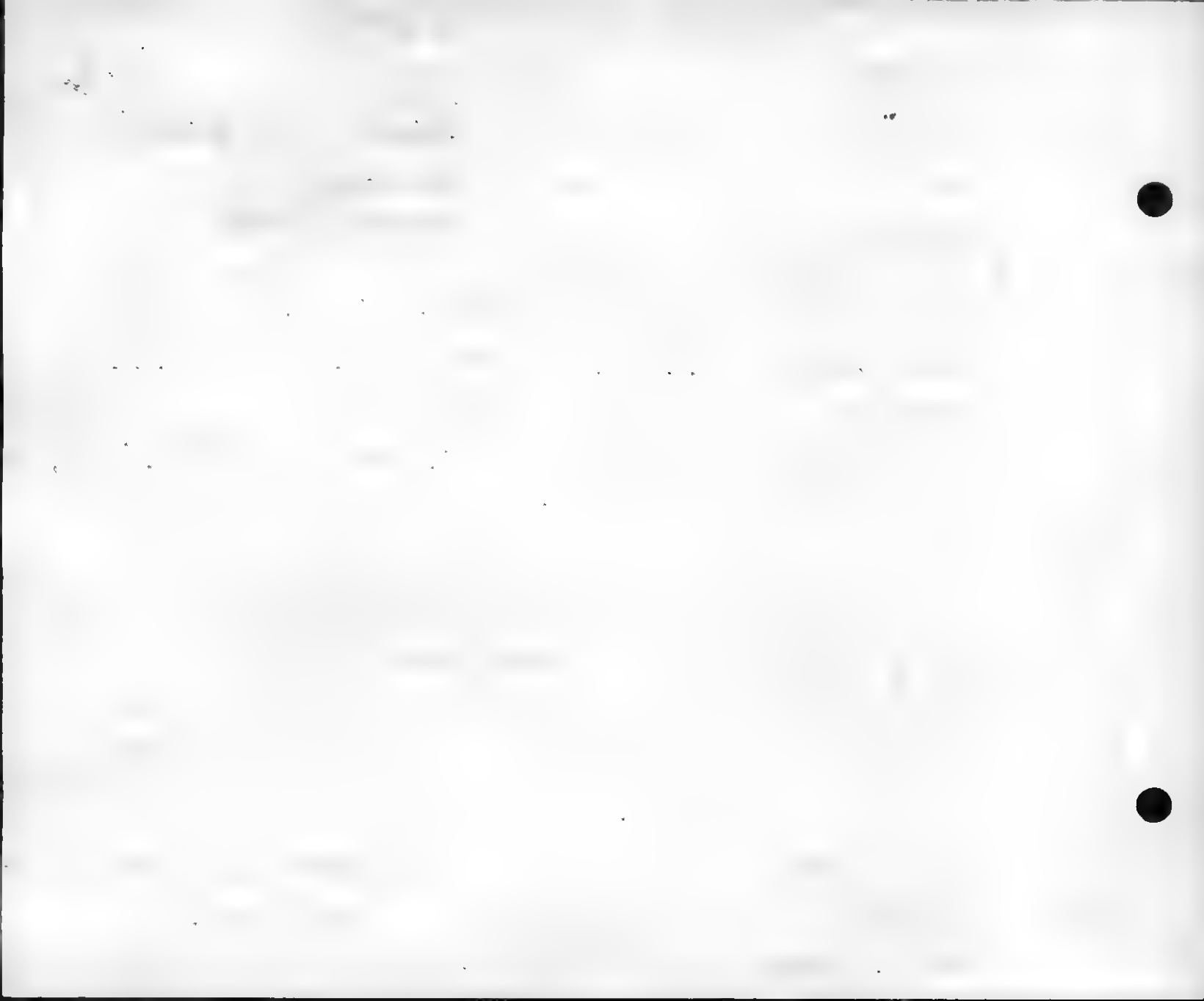
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08464		08459	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>Middlesex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>2 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waltham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1517 Forest Glen Road</u>		d. STREET ADDRESS <u>81 Middlesex Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dennis</u> First <u>J</u> Middle <u>Ryan</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Newton, Mass.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael Ryan</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Kennedy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO <u>034-12-3850</u>		17. INFORMANT <u>Thomas J. Lyons Funeral Home - W. Newton, Mass.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary artery Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/8/1967</u> to <u>6/14/1967</u> , that (I) (we) last saw the deceased alive on <u>6/13/1967</u> , and that death occurred at <u>6 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Kirchner</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-14-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Raymond C. Kirchner</u>		22d. ADDRESS <u>6480 New Hampshire Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Trans</u>	23b. DATE THEREOF <u>June 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Waltham, Mass.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>JUN 15 1967</u>	25a. REGISTRAR'S SIGNATURE <u>James J. Judge</u>



08465

CERTIFICATE OF DEATH

08460

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY IN 1b <u>21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cobb Island</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lillian</u> Last <u>SARACINO</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 20, 1903</u>	
				9. AGE (In years last birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Ignatius Downs</u>				14. MOTHER'S MAIDEN NAME <u>Frances Gaffney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Cobb Island</u> Address <u>Maryland</u> <u>BMC pasquale Saracino, USN, Ret.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from <u>May 22</u> , 19 <u>67</u> , to <u>June 12</u> , 19 <u>67</u> that (s) (we) last saw the deceased alive on <u>June 12</u> , 19 <u>67</u> , and that death occurred at <u>0900 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>13 June 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>D. R. Foreman, LT, MC, USN</u>	
22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/16/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cobb Issue, Maryland</u>	
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc.</u> <u>LaPlata, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

2000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

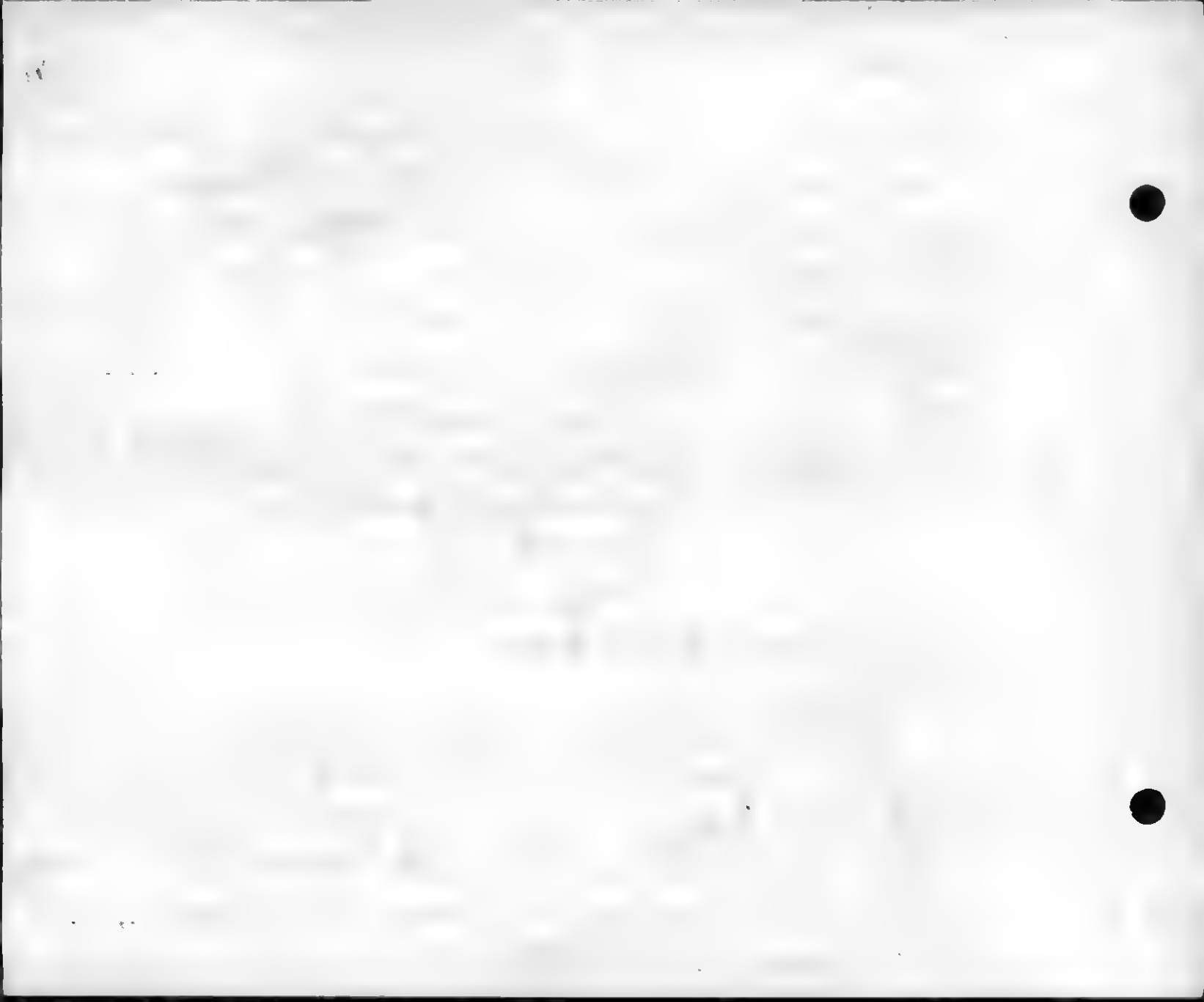
08466

08461

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE, MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>4600 HARBAN STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DINA</u> Middle <u>Sazonoff</u> Last <u>Sazonoff</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/88</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>(unknown) Bassman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>127-14-6241A</u>		17. INFORMANT <u>Divian Sande</u> Address <u>2116 9. Street, N. W. Washington, D. C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4701</u> DUE TO (b) <u>ascorv.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>old age</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debilitation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>67</u> to <u>June 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R. C. Bufalino</u>				22b. DATE SIGNED <u>June 14, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>R. C. BUFALINO, M.D.</u>	
22d. ADDRESS <u>1429 University Blvd. N. W. Silver Spring</u>		22e. MED ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>June 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>	
24a. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jozia</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

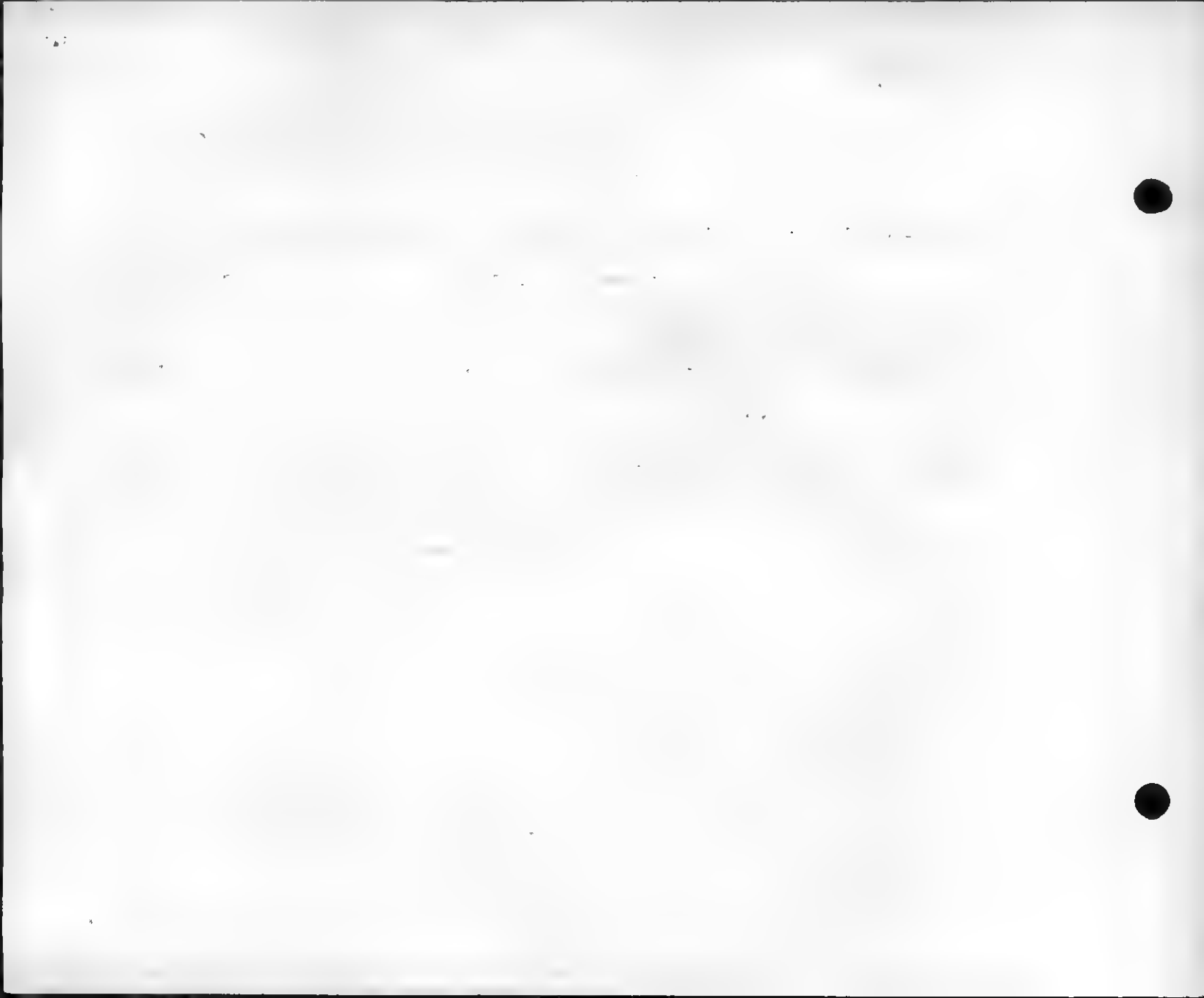
TO MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08467

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08462

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE New York b COUNTY Broome			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c LENGTH OF STAY IN 1b 7 1/2 hours			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				d STREET ADDRESS 321 Robble Avenue			
3 NAME OF DECEASED (Type or print) Patsy Frank Sbarra				4 DATE OF DEATH June 21 1967			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5-31-94	
9 AGE (In years last birthday) 73 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liquor Store Owner - Retired		10b KIND OF BUSINESS OR INDUSTRY Italy		12 CITIZEN OF WHAT COUNTRY? America	
13 FATHER'S NAME ? Sbarra				14 MOTHER'S MAIDEN NAME Rachell Cinotti			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) yes Army WW1				16 SOCIAL SECURITY NO 096-01-6085		17 INFORMANT Patient's chart	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemipericardium DUE TO (b) Hemorrhage great vessels at base of heart DUE TO (c) Chest injury							INTERVAL BETWEEN ONSET AND DEATH 8 1/2 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was found in wrecked car on street			
20c TIME OF DEATH Month Day, Year 6:30 p.m. June 20 1967				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street	
				20f (City or town) Hyattsville Pr. George Md.		(County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>[Signature]</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <i>[Address]</i>			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 6/24/67		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d LOCATION (City or town) (County) (State) Silver Spring, Md.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a REC'D BY REGISTRAR JUN 26 1967	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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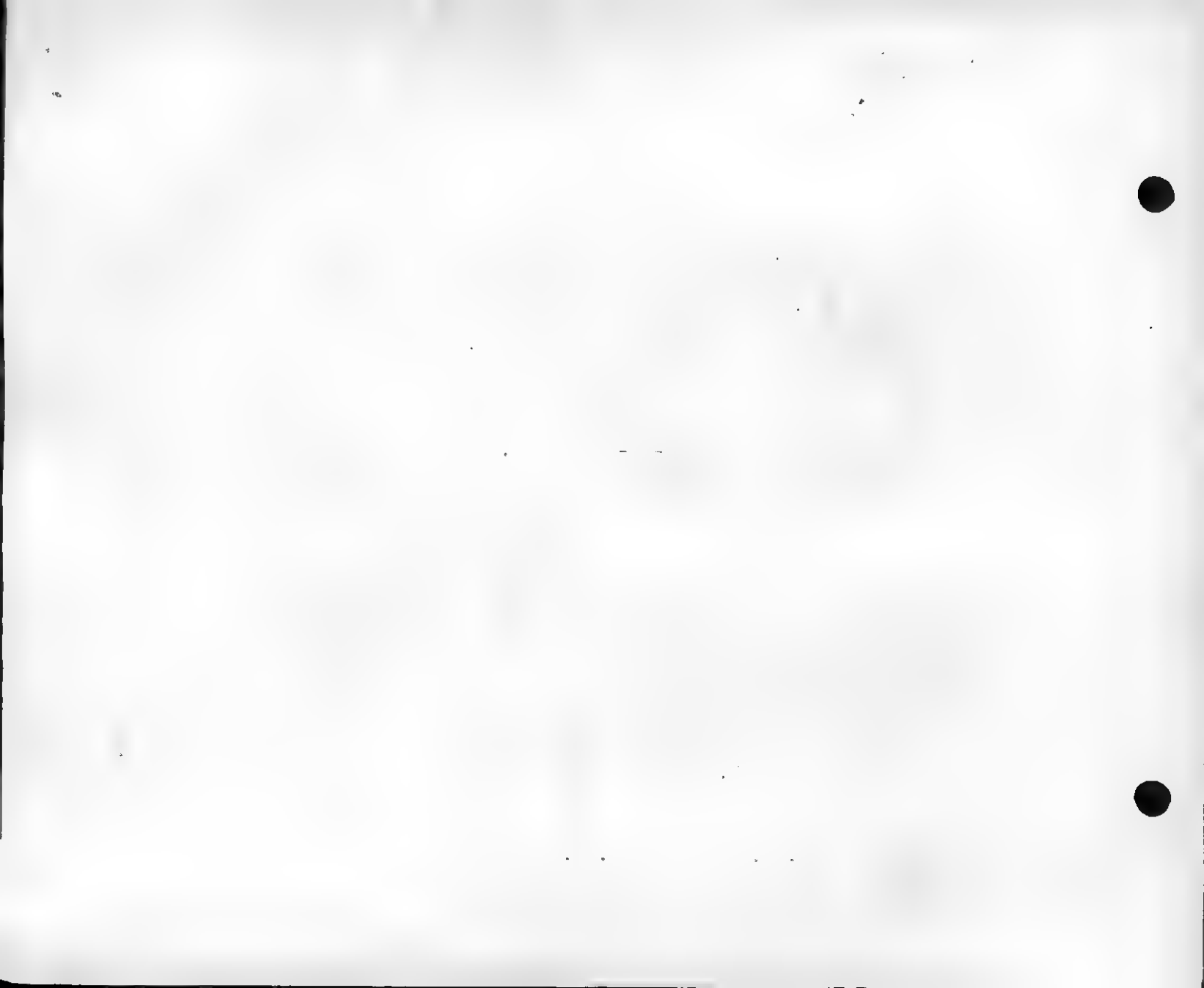
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20 M 1/66

08468

CERTIFICATE OF DEATH

08463

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,				c. LENGTH OF STAY IN "b" 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mattie I SCHAFFER				4. DATE OF DEATH Month June Day 28 Year 1967			
SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1892	
				9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cedar Grove, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Greenberry Eyler			
14. MOTHER'S MAIDEN NAME Melrina Biddinger				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 244-14-8208				17. INFORMANT Address Mr. A. Irving Schafer, Capland, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction due to unknown cause DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from June 20 , 19 67 , to June 21 , 19 67 , that he (we) last saw the deceased alive on June 21 , 19 67 , and that death occurred at 725 P.M. , from causes and on the date stated above.							
22a. SIGNATURE R. J. Kinney				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 June 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY M.D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/67		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Woodsboro, Md.	
24. FUNERAL DIRECTOR Barton Funeral Home				ADDRESS Walkersville, Md.		25a. REC'D BY REGISTRAR JUN 27 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE
HEALTH DEPT.

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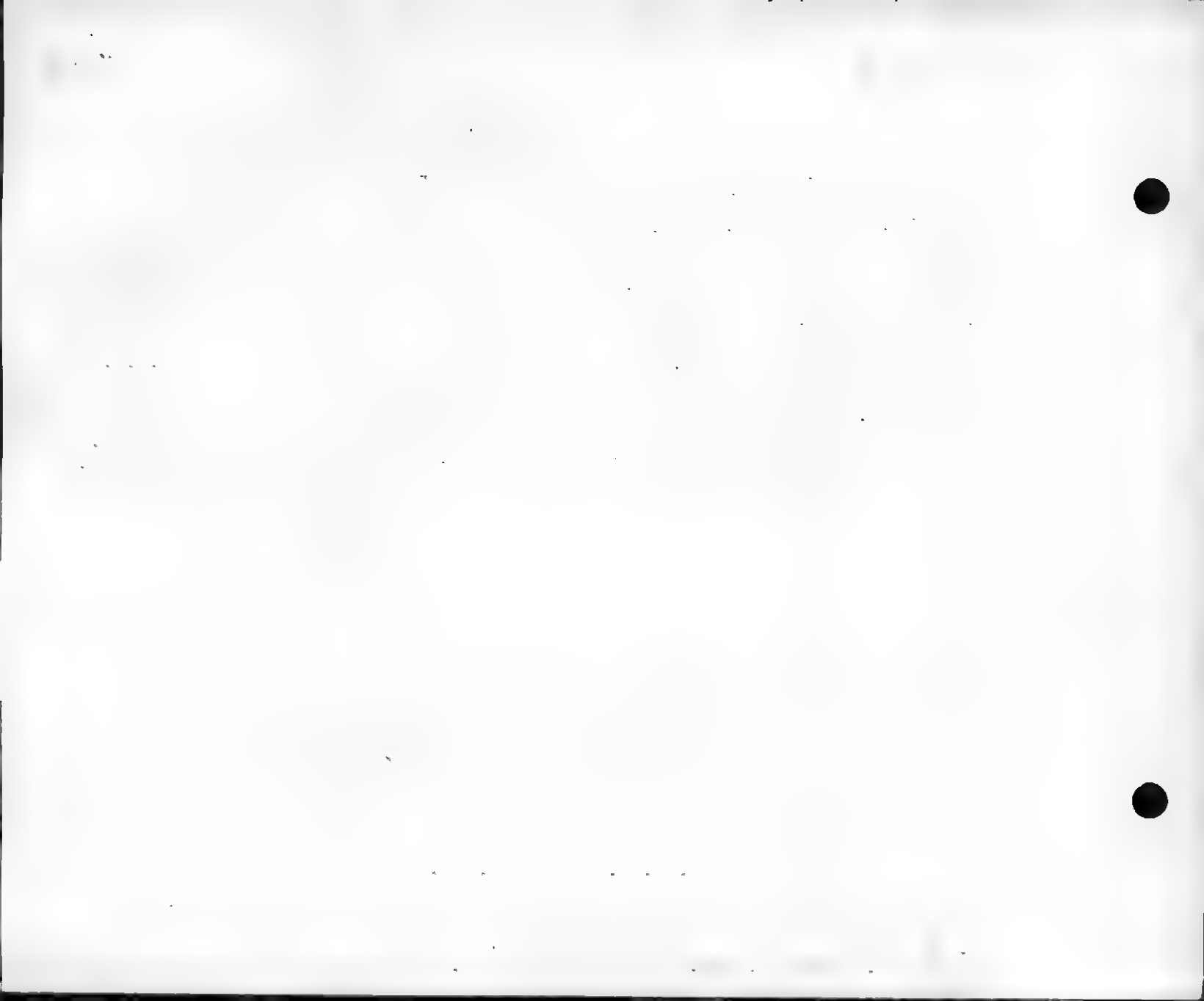
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6M 1 67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08464

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN b <u>27 years</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence Before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11022 Lockwood Dr.</u>				d STREET ADDRESS <u>11022 Lockwood Dr.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>C. Bailey Scrimgeour</u>				4 DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1967</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>June 4, 1899</u>	
9 AGE (in years last birthday) <u>67</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired engineer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>William M. Scrimgeour</u>			
14 MOTHER'S MAIDEN NAME <u>Lula Bailey</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO <u>579-44-8142</u>				17 INFORMANT <u>Maxwell Scrimgeour</u> Address <u>11020 Lockwood Dr. Silver Spring, Md.</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to carbon monoxide</u> DUE TO (b) <u>intoxication, and generalized third</u> stating the underlying cause (c) <u>degree burns</u> most							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVA. BETWEEN ONSET AND DEATH</u>							
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased burned in house fire.</u>			
20c TIME OF INJURY Month, Day, Year <u>158</u> Hour <u>6-1</u> <u>1967</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md</u>				21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>June 3, 1967</u>				23a BUREAU, CREMATION REMOVAL (Specify) <u>Burial</u>			
23b DATE THEREOF <u>June 3, 1967</u>				23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23d LOCATION (City or town) <u>Suitland</u> (County) <u>Maryland</u>				24 FUNERAL DIRECTOR <u>Glen Carter</u> Address <u>8434 Georgia Avenue</u>			
25a REC'D BY REGISTRAR <u>Charles Judge</u>				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
25c DATE <u>JUN 8 1967</u>				25d REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATE



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT

08470

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08465

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c LENGTH OF STAY IN 1b <u>27 years</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11022 Lockwood Dr.</u>				d STREET ADDRESS <u>11022 Lockwood Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Evelyn Thornton Scrimgeour</u>				4 DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH <u>May 21, 1902</u>	9 AGE (In years last birthday) <u>65</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Walter Thornton</u>				14 MOTHER'S MAIDEN NAME <u>Kate Waddington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-46-2763</u>		17 INFORMANT <u>William Scrimgeour</u> Address <u>4832 Oxford Dr., S. E. Washington, D. C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized third degree burns with</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>asphyxia due to smoke and heat inhalation</u>							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased burned in house fire.</u>			
20c TIME OF INJURY Month, Day, Year <u>158</u> Hour <u>am</u> <u>6-1</u> <u>1967</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Belden Reap</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Wheaton, Md.</u>			
				Address (Street, city, town, or county) <u>June 2, 1967</u>			
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>June 3, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City or Town) <u>Suitland, Maryland</u> (County) (State)	
24 FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a REC'D BY REGISTRAR <u>JUN 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

21



MD
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CASE CLEARED WITH MEDICAL EXAMINER

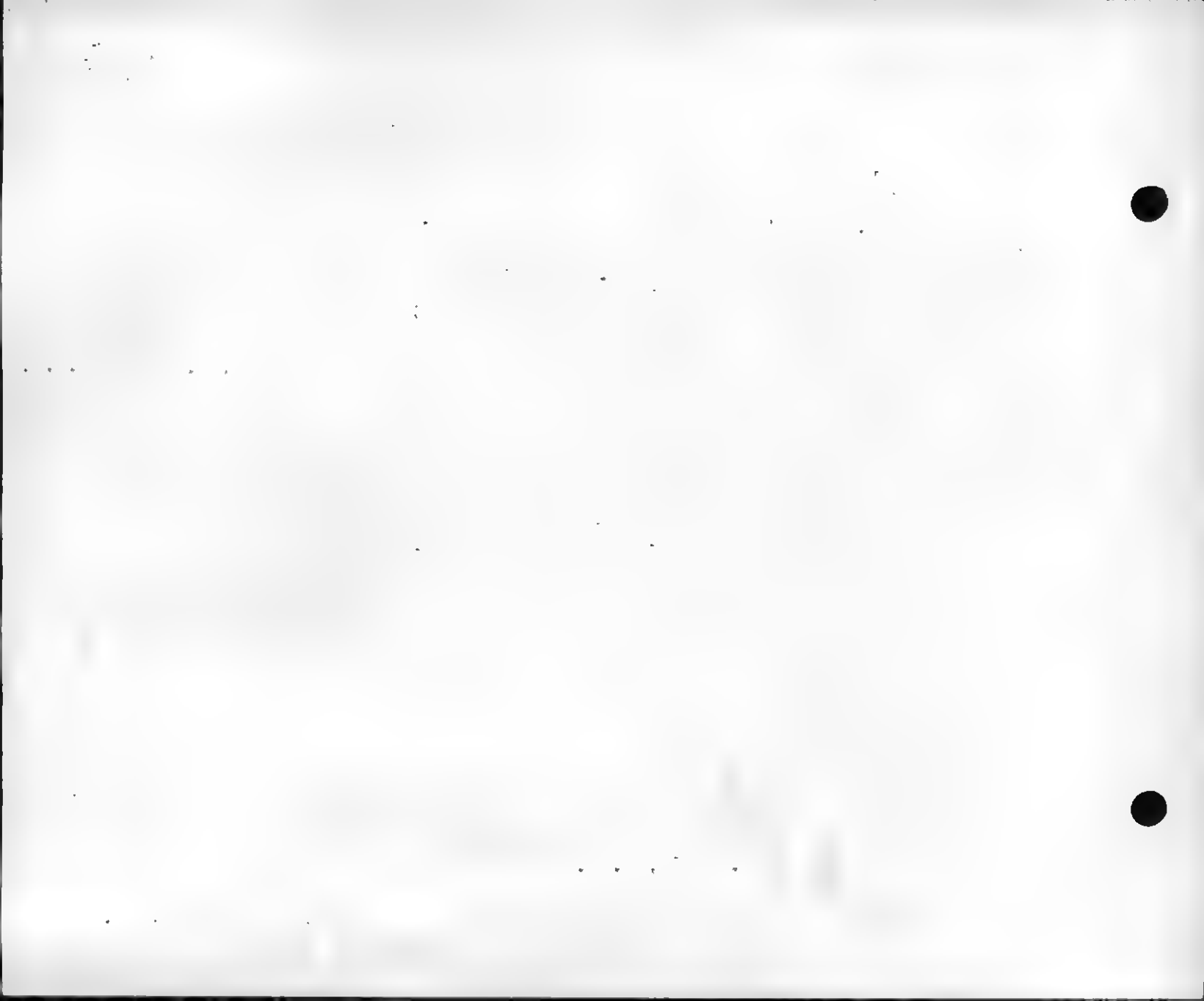
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 16		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTG. GENERAL HOSPITAL				d. STREET ADDRESS Mt. Zion Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Joshua M. Selby		4 DATE OF DEATH Month June Day 10 Year 1967		5 SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/31/87		9 AGE (In years last birthday) 79 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm work		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (County & State, or foreign country) Montgomery County, Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joshua Selby		14. MOTHER'S MAIDEN NAME Christine Budd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO unknown	
17 INFORMANT Montgomery General Hospital records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DISEASE - SUDDEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ASCHD - H.C.V.D. (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 1/25 1/25		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC CONGESTIVE HEART FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from August 1, 1964 to 6/10, 1967 , that (II) (we) last saw the deceased alive on 6/5, 1967 , and that death occurred at 2:17 M, from causes and on the date stated above.		22a. SIGNATURE Donald R. Lewis	
22b. DATES SIGNED 6/10/67		22c. PHYSICIAN'S NAME (Type) Donald R. Lewis, M.D.		22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY MT ZION CEMETERY		23d. LOCATION (City or Town) MT. ZION, MONTG. MD.		(County) (State)	
24. FUNERAL DIRECTOR George P. ...		25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles ...		25c. REGISTRAR'S NAME Charles ...		25d. REGISTRAR'S ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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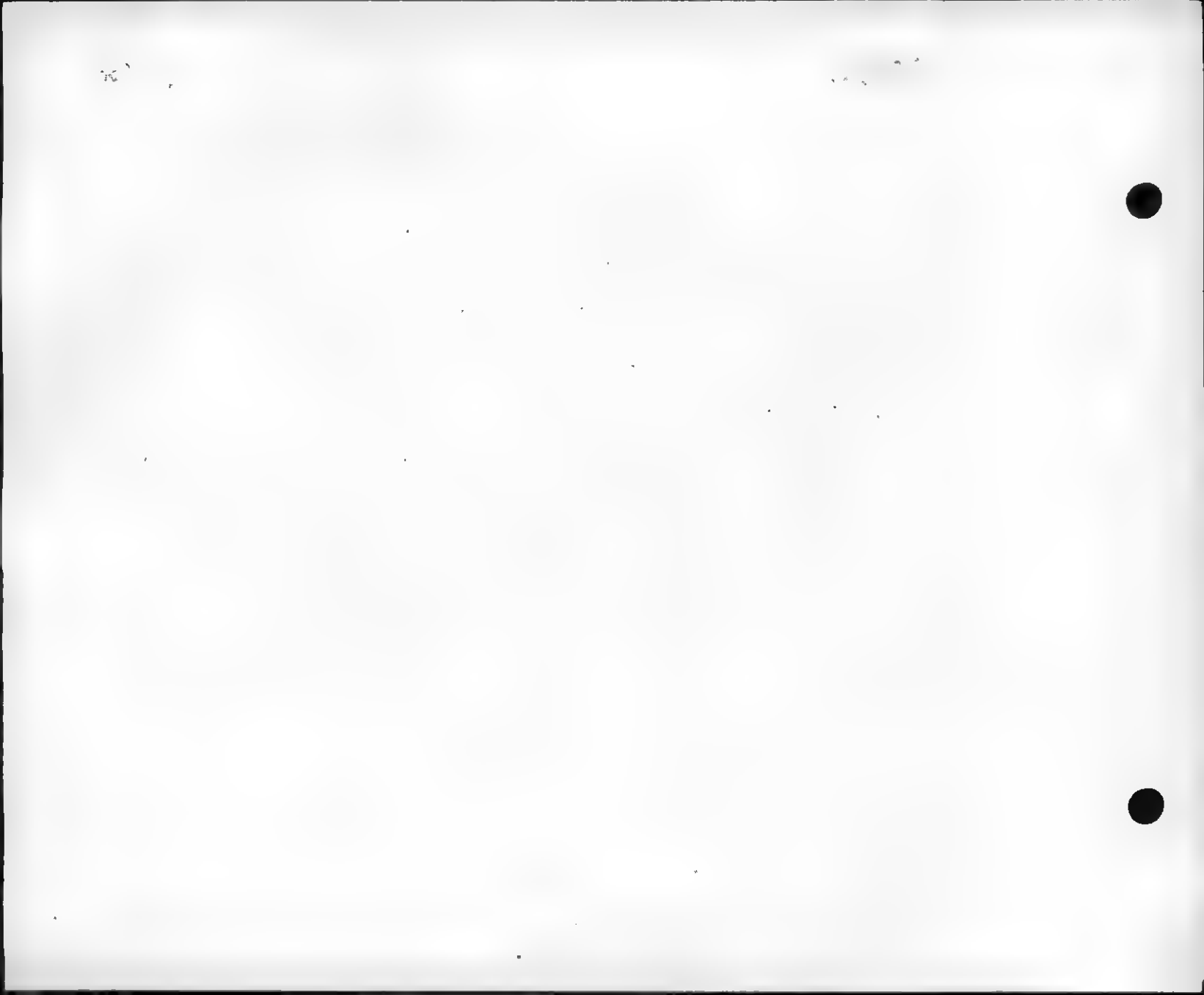
CERTIFICATE OF DEATH

08467

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>193 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gettysburg</u> <u>75-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>R.D. #5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theresa Ann Shanebrook</u>				4. DATE OF DEATH Month Day Year <u>June 27, 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 February 1943</u>		9. AGE (In years last birthday) <u>24</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl A. McMaster</u>				14. MOTHER'S MAIDEN NAME <u>Jane Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>198-32-9698</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral lobar pneumonia</u> <u>200.1</u> DUE TO (b) <u>Lymphosarcoma with acute lymphocytic leukemia</u> 12 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from <u>December 12, 1966</u> , to <u>June 27, 1967</u> , that he (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>6:45 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Myron J. Levin</u>				22b. DATE SIGNED <u>27 June 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Myron J. Levin, MD.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>30 June 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		23d. LOCATION (City or town) (County) (State) <u>Bonneauville Adams Pa</u>	
24. FUNERAL DIRECTOR <u>H.F. Walter</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>June 30 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MDARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

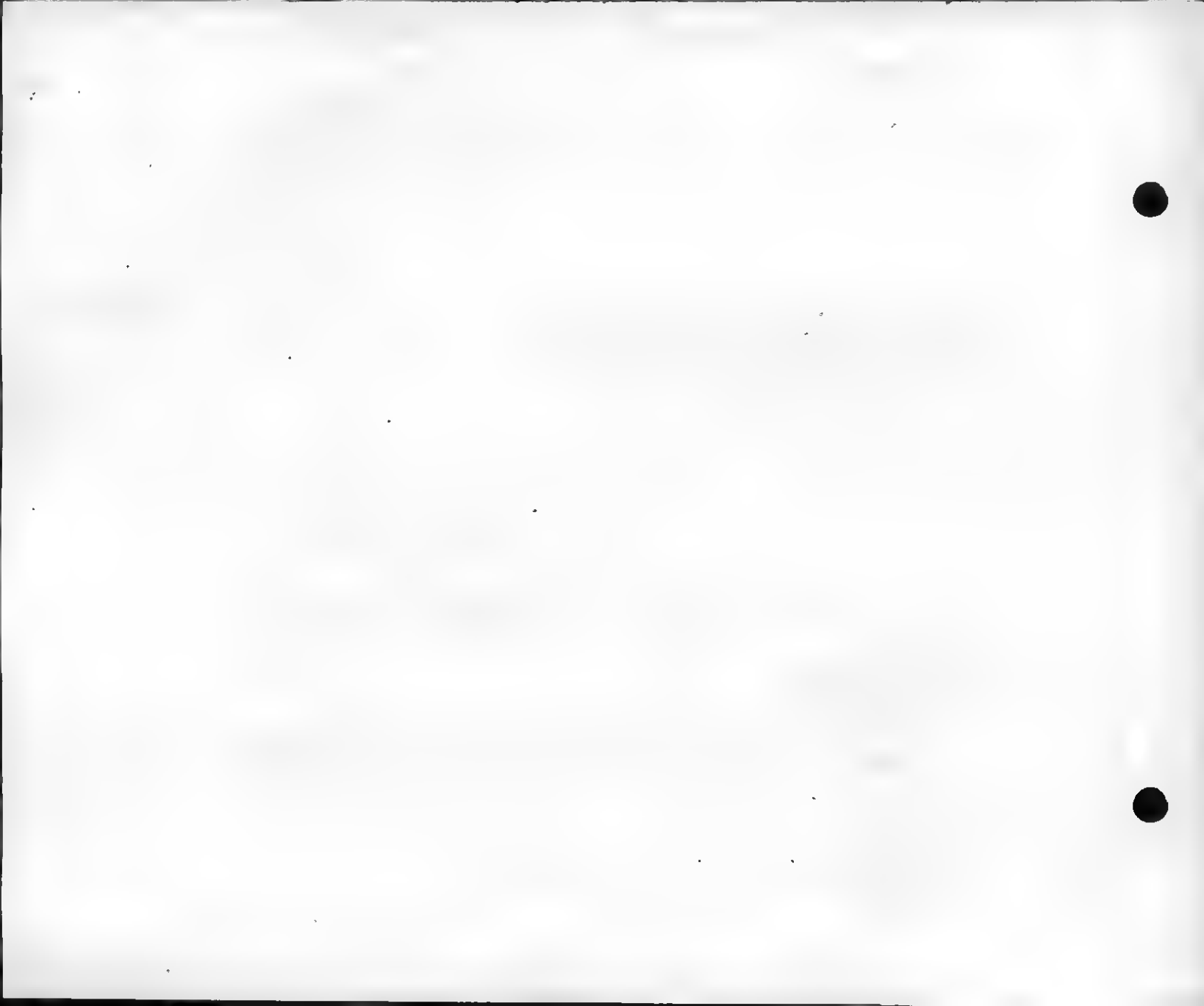
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1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DC b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SILVER MANOR HEALTH CARE CENTER			d. STREET ADDRESS 2615 Wisconsin Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First MABEL Middle SHEA Last SHEA			4 DATE OF DEATH Month JUNE Day 13 Year 1967		
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/22/1897		9 AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11 BIRTHPLACE (County & State, or foreign country) Bellevue, Ohio	
13. FATHER'S NAME JAMES SHEA			14. MOTHER'S MAIDEN NAME CATHERINE OBINS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 578-01-3048		17 INFORMANT (Sister) Address Mrs. A.T. Willick WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar artery thrombosis 32X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 1965 to June 13, 1967 , that (I) (we) last saw the deceased alive on June 13, 1967 and that death occurred at 8:05 PM , from causes and on the date stated above.					
22a. SIGNATURE Robert T. Thibadeau		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-13-67	
23c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU		23d. ADDRESS ROCKVILLE MD 20852			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-15-67		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
23d. LOCATION (City or Town) WASHINGTON D.C.		(County)		(State)	
24. FUNERAL DIRECTOR James E. DeVol, Wash. D.C.		ADDRESS		25a. REC'D BY REGISTRAR JUN 23 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if removed, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

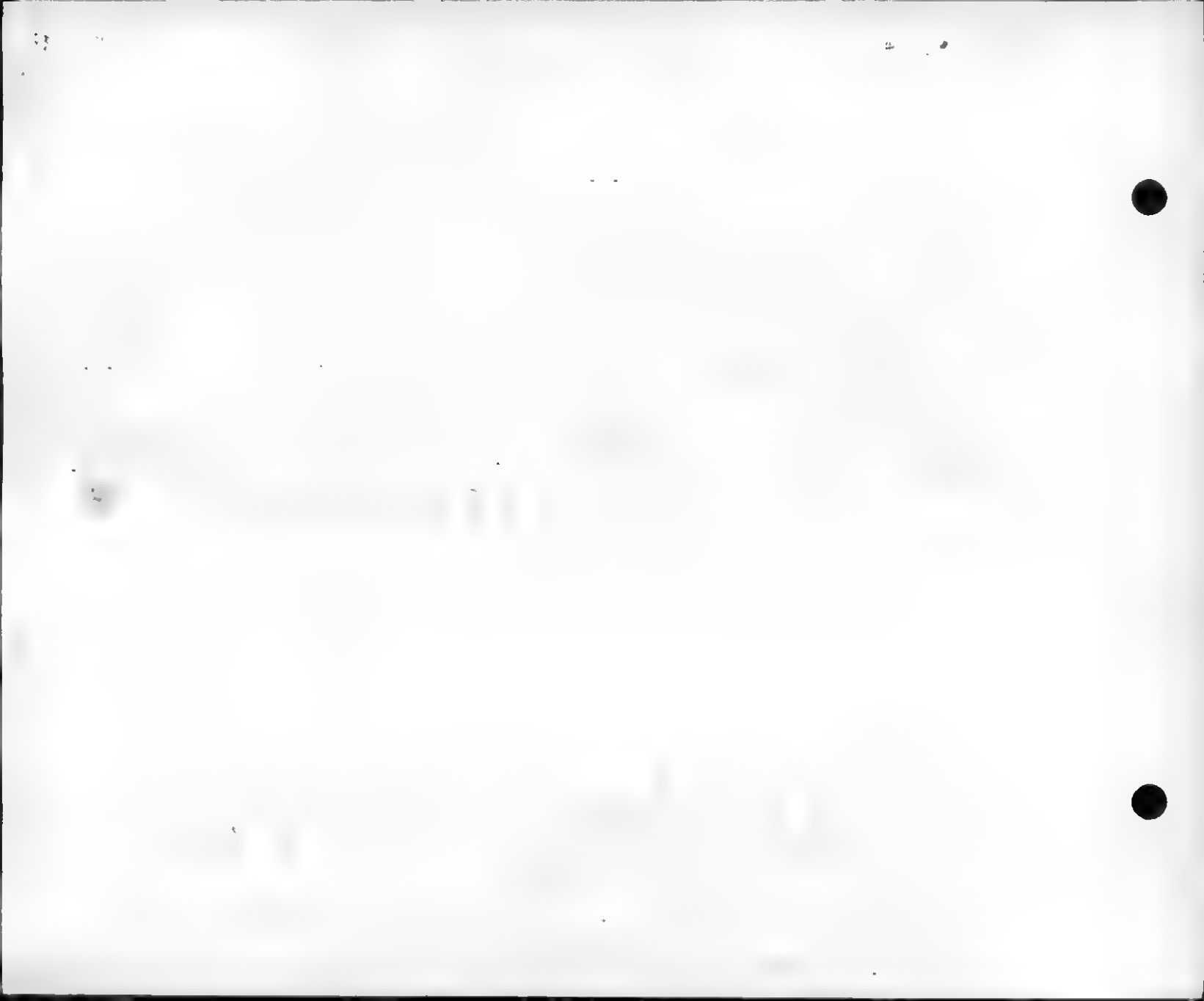
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FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gakoma Park</u>		c. LENGTH OF STAY IN b. <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>		d. STREET ADDRESS <u>114 Hamilton Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Joseph Shipley</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. CO. OR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-03</u>
9. AGE (In years lost birthday) <u>63</u>		10. F UNDER 1 YEAR Months <u>6</u> Days <u>15</u> IF UNDER 24 HRS. M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Repair</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ruben Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Corby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-01-6632</u>	
17. INFORMANT <u>Mr. Russell Shipley</u>		Address <u>5206 Blacksnake Hill Crest Heights, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>	
24. F. NEAR DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
ADDRESS <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		DATE <u>JUN 21 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



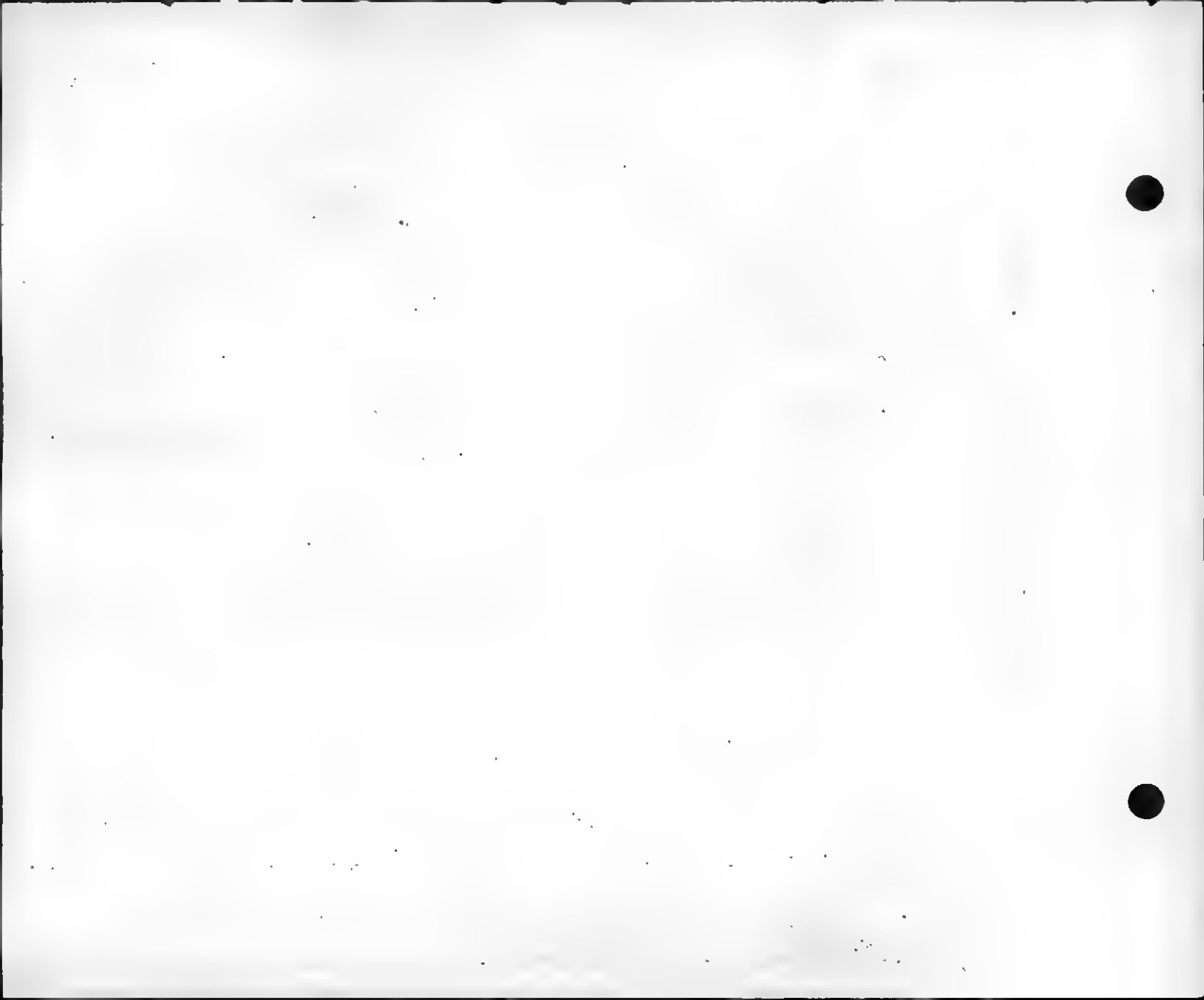
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CLEARED BY MEDICAL EXAMINER - DR. ROGERS

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN ID <u>3 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>Glenallen</u> <u>1417 Glenallen Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Alice</u>		First		Middle <u>L.</u>		Last <u>Singer</u>		4. DATE OF DEATH Month <u>June</u>		Day <u>21</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/22/04</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>French D. Bussey</u>						14. MOTHER'S MAIDEN NAME <u>Bessie B. Beattle</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>579-48-9677</u>		17. INFORMANT <u>Jessie N. Seymour</u>		Address <u>1417 Glenallen Avenue</u> <u>Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory - cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor pulmonale + acidosis</u> DUE TO (c) <u>Pulmonary Hypertension</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>June 14, 1967</u> to <u>June 21, 1967</u> , that (1) (we) last saw the deceased alive on <u>6:30</u> <u>1967</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward J. Richards</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 21, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>						22d. ADDRESS <u>11011 Georgia Ave., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Switland, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JUN 28 1967</u>											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

38476

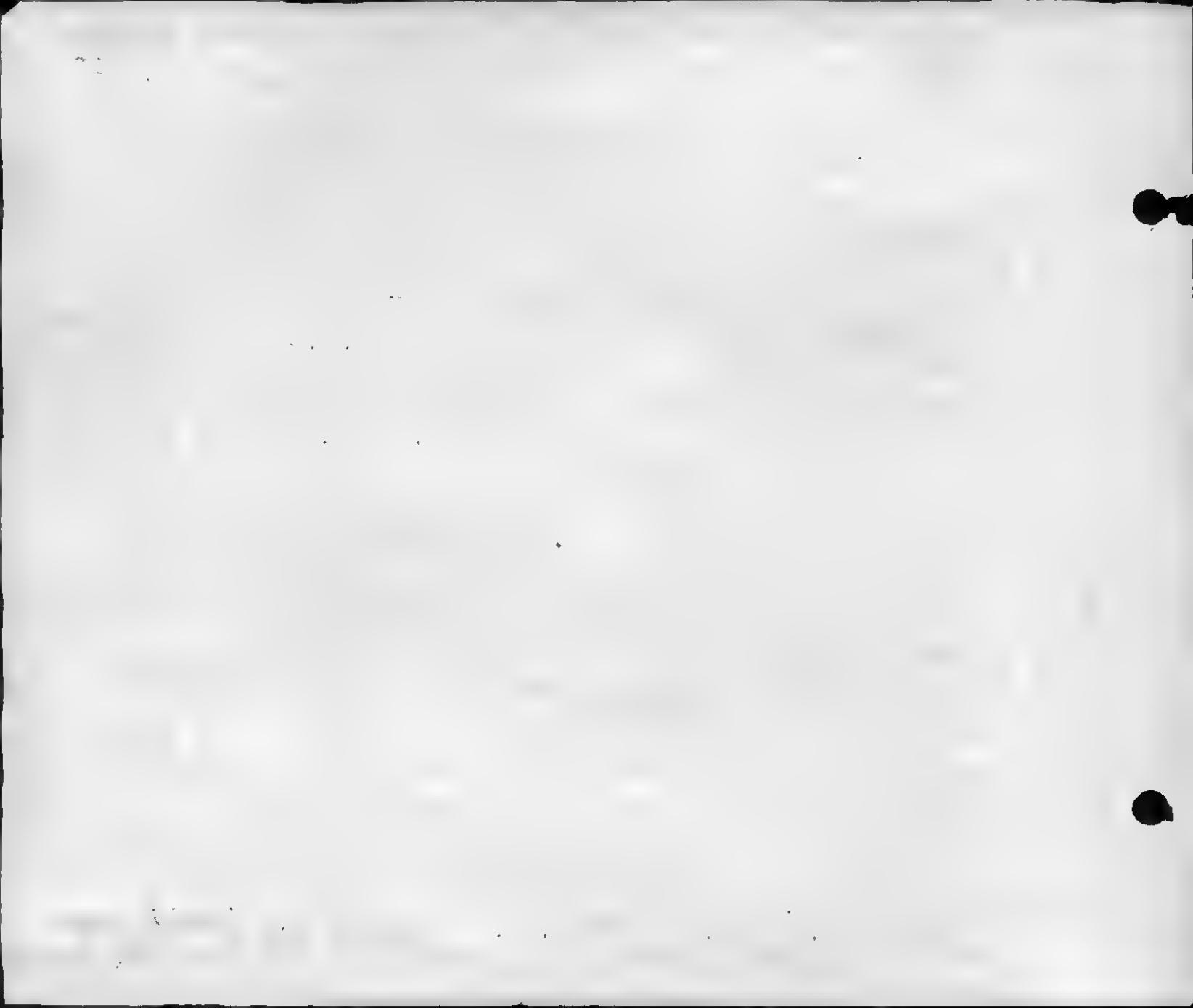
CERTIFICATE OF DEATH

08471

Item #9 Film #5-14767 pc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 2yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Rolling Road		d. STREET ADDRESS 200 rolling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dessie		First Londa		Last Sisler	
4. DATE OF DEATH June 7th 1967		Month June		Day 7th	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 23-1882		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Preston Co. W.Va	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Zachariah Smith		14. MOTHER'S MAIDEN NAME Susan Wilhalm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Paul A. Sisler. As No 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO <u>F.I.T.O.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart</u> (c) <u>Minutes</u> <u>Year</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 1965, to 6-7-67, that (I) (we) last saw the deceased alive on MAY 25 1967, and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Jack Williams</u>		M.D.		22b. DATE SIGNED 6-8-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-67		23c. NAME OF CEMETERY OR CREMATORY Terra Alta	
23d. LOCATION (City, town or county) Terra Alta. W.Va		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		ADDRESS Gaithersburg. Md.		25a. REC'D BY REGISTRAR JUN 12 1967	
25b. REGISTRAR'S SIGNATURE <u>John C. Gartner</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

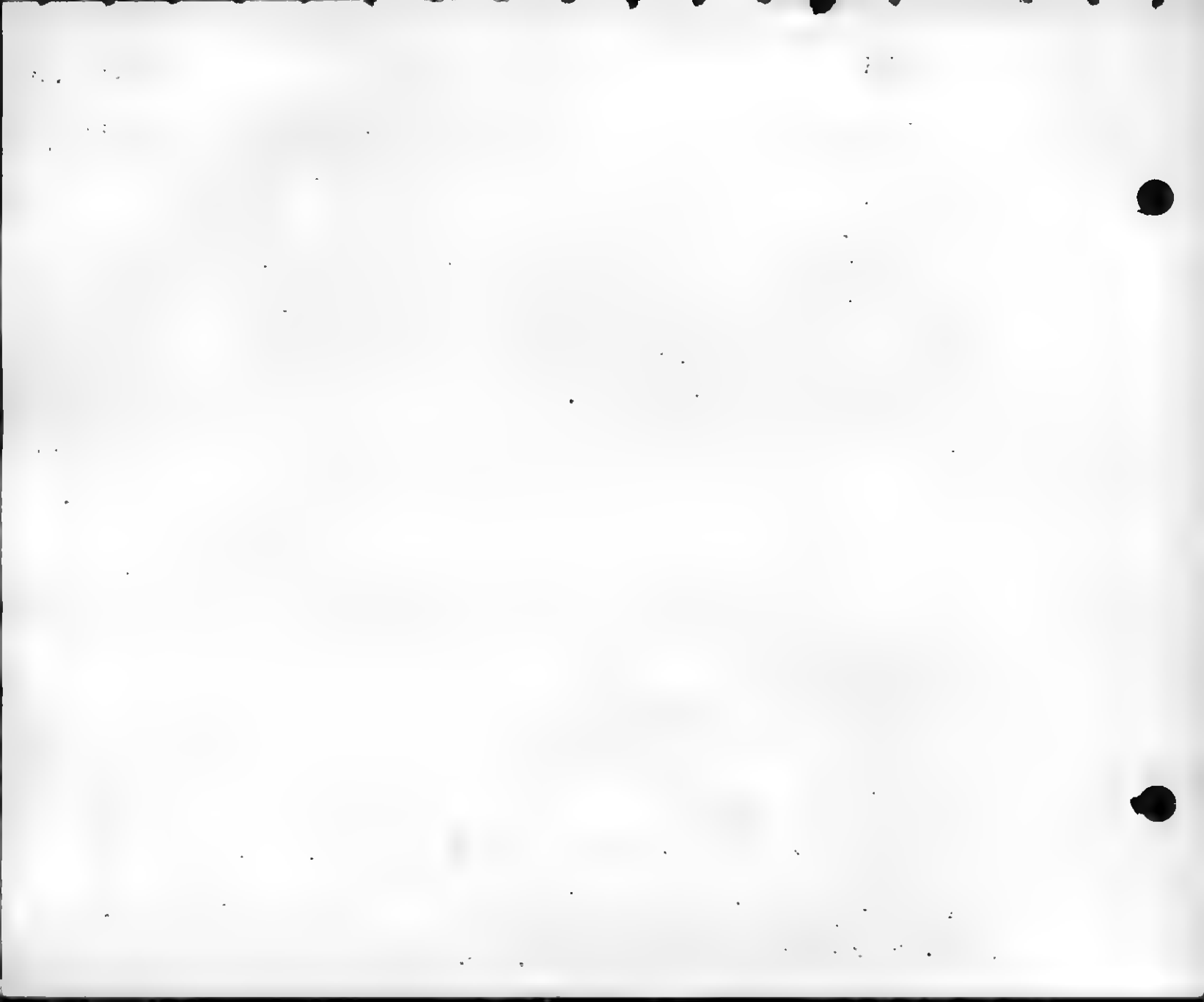
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08477

08472

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>1101 Slys Court</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1101 Slys Court</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Esther Anna Slys</u>				4. DATE OF DEATH <u>June 20 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/1910</u>	
9. AGE (in years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State of Maryland Employment Serv</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Humpherson</u>				14. MOTHER'S MAIDEN NAME <u>Anne Foster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry H. Slys</u> Address <u>Same as #2 above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases.</u> 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>19 months.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> to <u>4/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>67</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard M. Hoffman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD HOFFMAN</u>				22d. ADDRESS <u>2001 - EYE STREET, N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>June 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20012</u>				DATE <u>JUN 26 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 File #1379 6/15/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

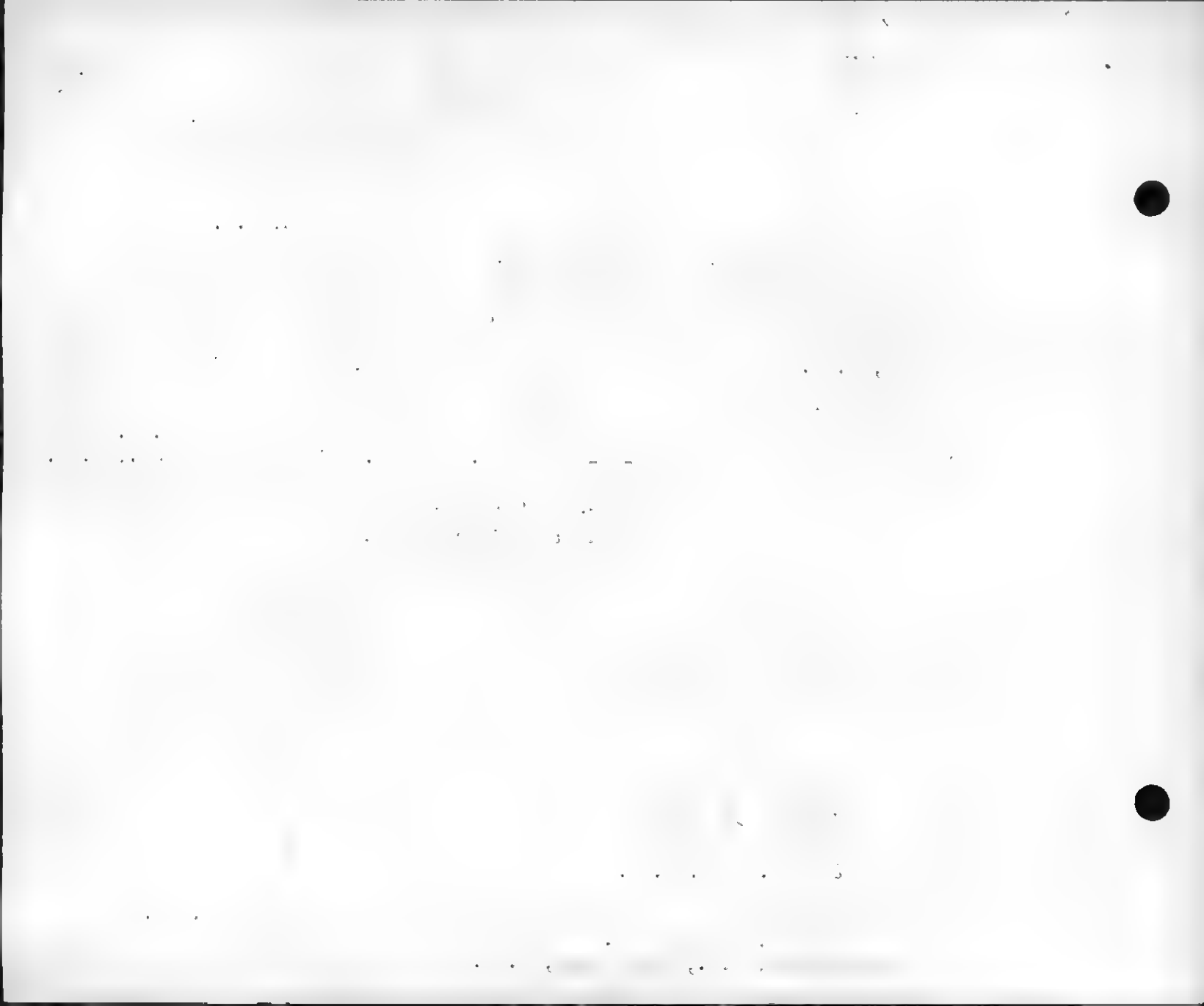
08478

08473

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 5901 7th Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Darwin Enoch SMITH		4 DATE OF DEATH Month Day Year June 5 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 9, 1893/ 73 AGE (In years lost birthday) 73 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain, U. S. Army		9b. KIND OF BUSINESS OR INDUSTRY	
10. FATHER'S NAME Samuel Smith		11. BIRTHPLACE (State or foreign country) Pittsburg, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME Rosa Eaton	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		15. SOCIAL SECURITY NO 579-48-1324	
16. INFORMANT Washington, D. C.		17. Address Mrs. Ethel E. Smith, 5901 7th St., N. W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute H201 DUE TO Coronary arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 minutes years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) John G. Ball, M. D.		22. DATE SIGNED 6 June 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR John T. Rhines & Co. 3015 12th Street, N.W., Washington, D. C.		25a. REGISTRATION JUN 12 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

08473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08474

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Virginia</u> b COUNTY <u>Rockbridge</u>			
b CITY OR TOWN (If outside corporate limits write RJRAL and give nearest town) <u>Lexington</u>				c LENGTH OF STAY IN b <u>2</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d STREET ADDRESS <u>St. #4</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>George Edward Smith</u>				4 DATE OF DEATH Month Day Year <u>June 11 1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>July 3, 1923</u>		9 AGE (in years last birthday) <u>43</u> yrs	10 FUNDING YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11 BIRTHPLACE (State or foreign country) <u>Virginia - Rockbridge County</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Edward Davis</u>				14 MOTHER'S MAIDEN NAME <u>Martha Elizabeth Smith</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>Hospital Records</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to Drowning</u> 729.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 min.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>20b. Went in swimming in river and drowned</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day, Year Hour <u>3:30</u> p.m. <u>6/11</u> 19 <u>67</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>		20f (City or town) (County) (State) <u>Montg. Md.</u>	
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				22. DATE SIGNED <u>[Signature]</u>			
EXAMINER'S NAME (Type) <u>D. H. Erickenberger</u>				Address (Street, city, town or county) <u>Lexington, Va.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>6-16-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>New Monmouth</u>		23d LOCATION (City or town) (County) (State) <u>Rockbridge Co., Virginia</u>	
24 FUNERAL DIRECTOR <u>Harrison Fun'l. Home</u>				25 REC'D BY REG. CLERK <u>[Signature]</u>			
26 DATE <u>JUN 15 1967</u>				27 REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

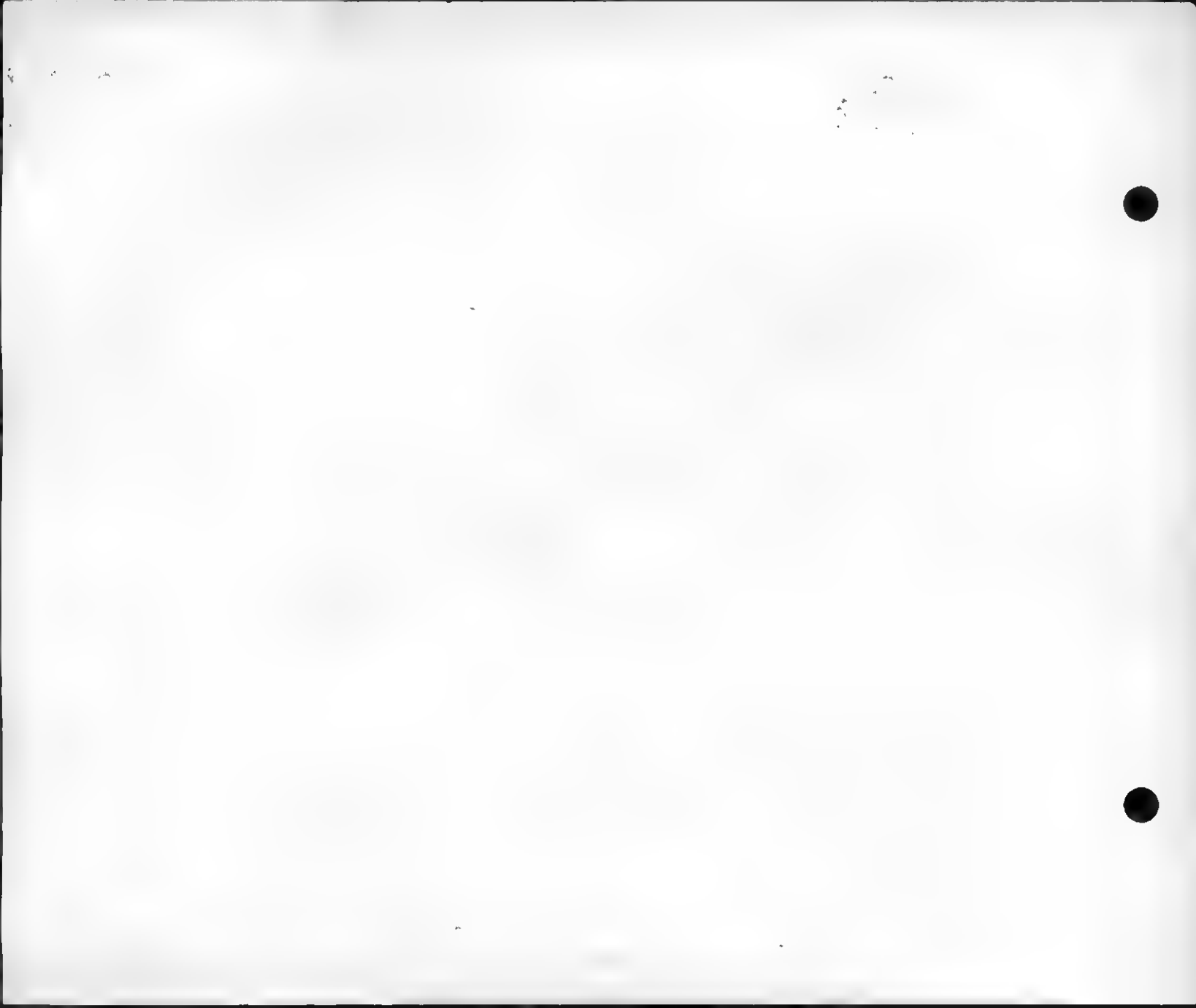
CERTIFICATE OF DEATH

08475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 37 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium			d. STREET ADDRESS 5124 33rd St Wash. D.C.		
3. NAME OF DECEASED (Type or print) First Middle Last Hugh P. Smyth			4. DATE OF DEATH Month Day Year 6 - 1 19 67		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1983		9. AGE (In years last birthday) 84 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Smyth			14. MOTHER'S MAIDEN NAME Margaret Doyle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-60-1738		17. INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) () DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) EMPHYSEMA					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. None		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) None		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to June 1, 1967 , that (I) (we) last saw the deceased alive on MAY 31, 1967 , and that death occurred at 10 P.M. from causes and on the date stated above					
22a. SIGNATURE James M. Hoffus		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED JUNE 1, 1967	
22c. PHYSICIAN'S NAME (Type) JAMES M. Hoffus MD		22d. ADDRESS 5475 Connecticut Ave Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-5-1967	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or Town) (County) (State) WASH. D.C.	
24. FUNERAL DIRECTOR Harlan F.H.		25a. RECEIVED IN REGISTRAR DATE JUN 6 1967		25b. REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

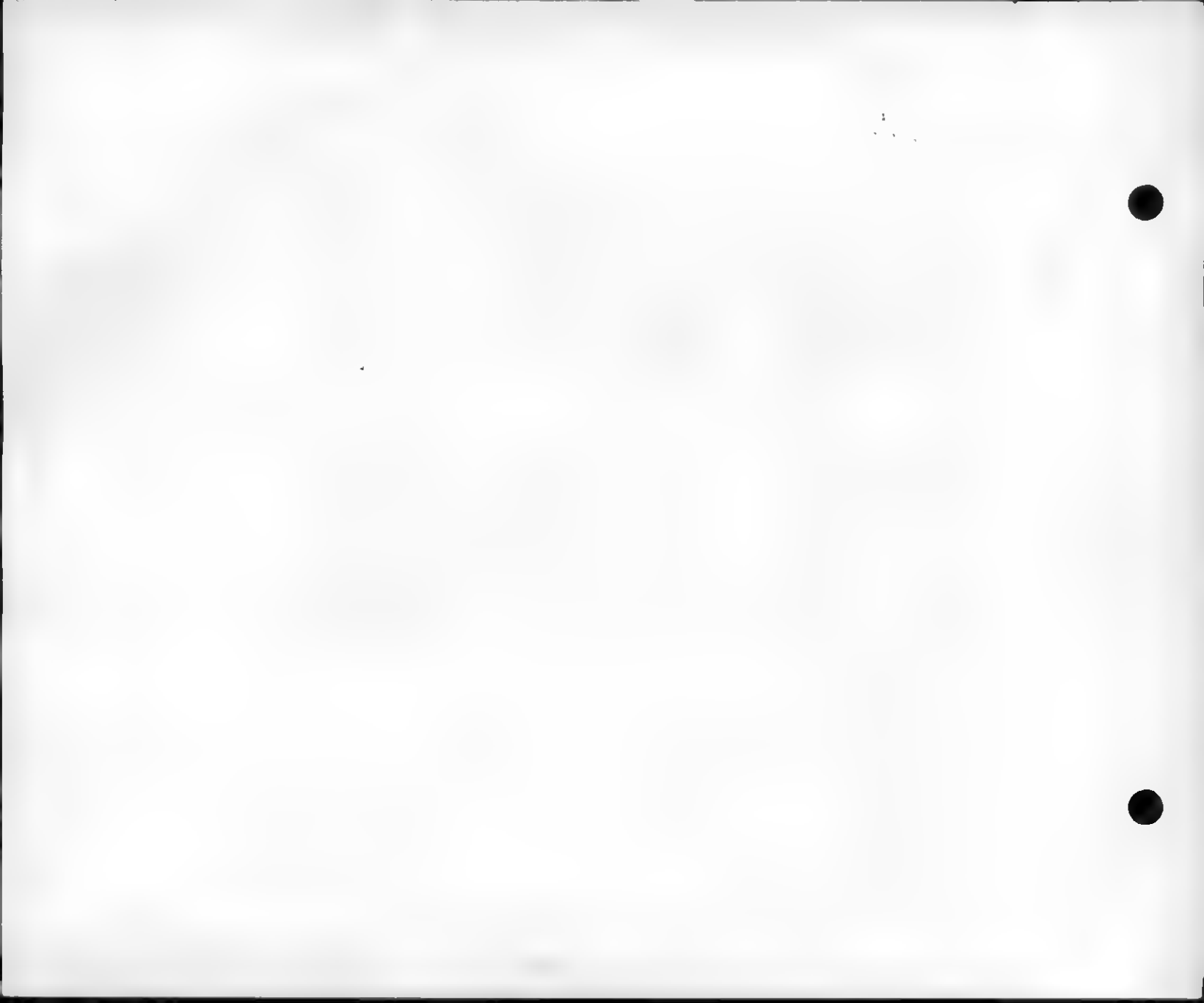
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

28481

38879

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>47</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY in it <u>21 months - 4 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Smyth</u>		4 DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MARCH 28 - 1889</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
10 BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		11 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
12 FATHER'S NAME <u>Charles BOARER</u>		13 MOTHER'S MAIDEN NAME <u>Margaret GALVIN</u>	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		15 SOCIAL SECURITY NO <u>579-60-1738</u>	
16 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of liver</u> 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Colon</u> DUE TO (c) <u>None</u>		17 INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		18b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
19a TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> p.m. <u>None</u>	19b INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	19c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	19d (City or town) (County) (State)
20 I certify that (I) (this hospital) attended the deceased from <u>June 30, 1966</u> to <u>June 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 30, 1967</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
21a SIGNATURE <u>James M. Hofstus</u>		21b DATE SIGNED <u>6/29/67</u>	
22a PHYSICIAN'S NAME (Type) <u>JAMES M. HOFSTUS</u>		22b ADDRESS <u>415 - ...</u>	
23a BURIAL, CREMATION, or other disposition (Specify) <u>None</u>	23b DATE THEREOF <u>7/1/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24 FUNERAL DIRECTOR <u>HANLON FUNERAL HOME - WASH. D.C.</u>		25a REC'D BY REGISTRAR DATE <u>JUL 12 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08482

08476

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN It <u>2 yrs 10 mo 16 Days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>3800 - McCall St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>S.</u> Last <u>Springarn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1876</u>	
9. AGE (In years and birthday) <u>91 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ROMANIA</u>	
13. FATHER'S NAME <u>Frederick Sachtel</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>219-54-8440</u>		17. INFORMANT <u>Mrs. Lucie Bratenahl, WASH., D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> DUE TO <u>general debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general debility</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pemphigoid retin. c sec. Staphylococcal infection</u>						19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19-64</u> to <u>6-16-67</u> , that (I) <u>was</u> last saw the deceased alive on <u>6-15-67</u> , and that death occurred at <u>1:45 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>R. F. Sengstack M.D.</u>				22b. DATE SIGNED <u>6-16-67</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE F. SENGSTACK, M.D.</u>	
22d. ADDRESS <u>9241 COL. BLVD, SILVER SPRING, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>6/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREM.</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>Joseph Loulen Son, Washington D.C.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
25c. ADDRESS <u>5130 WISCONSIN AVE.</u>				25d. DATE <u>JUN 26 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

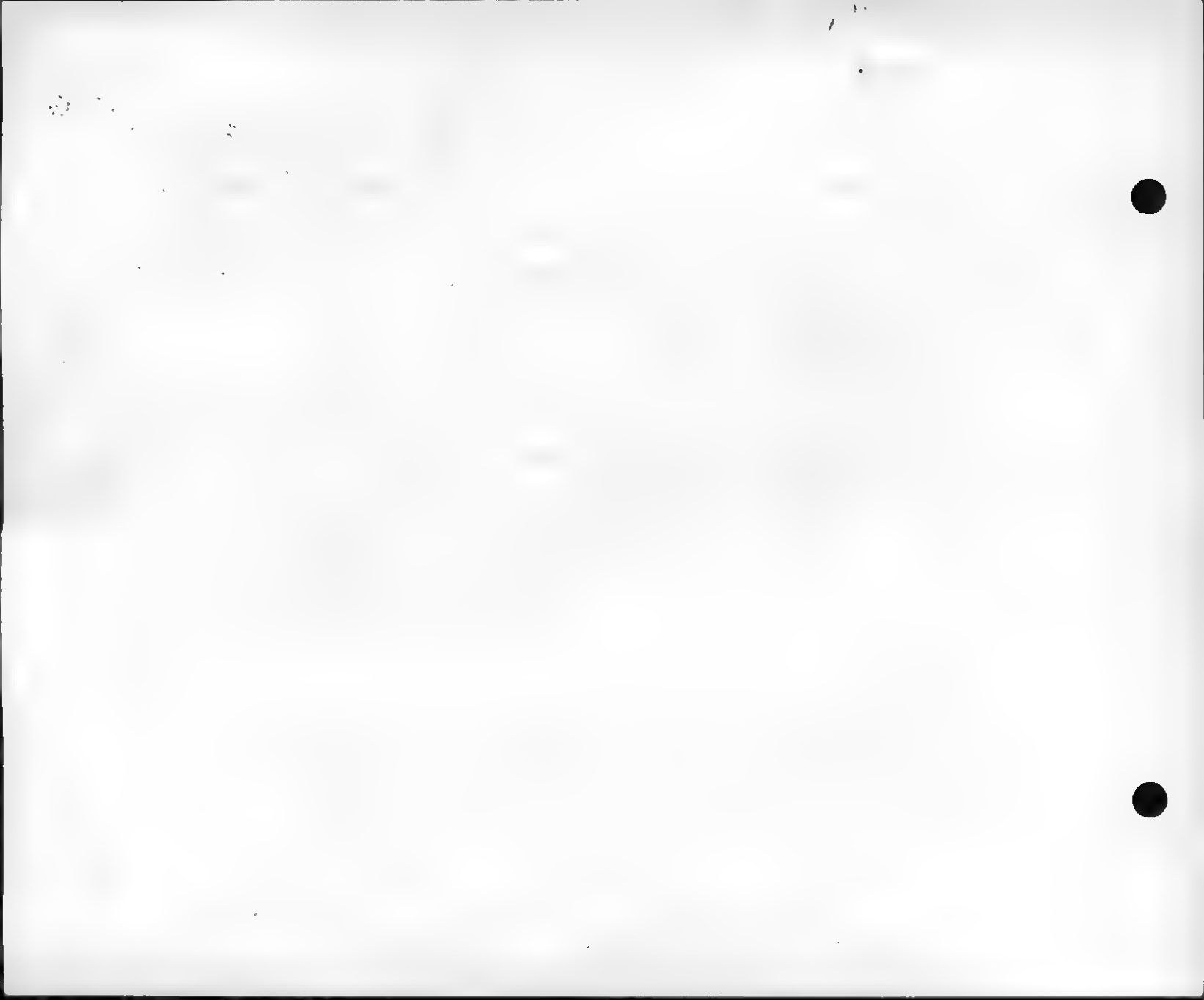
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, on page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18 & 21 Film 390
7-13-67 am
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Cherry Hill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Robert Zelefer Spry</u> First Middle Last 4 DATE OF DEATH <u>JUNE 17 1967</u> Month Day Year		5 SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>Aug 7-22 44</u> 9 AGE (in years last birthday) <u>22</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM MANAGER</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>IRVING SPRY</u> 14. MOTHER'S MAIDEN NAME <u>HELEN CRADDOCK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of dates of service) <u>YES U.S. II</u> 16. SOCIAL SECURITY NO <u>214-18-4094</u> 17 INFORMANT <u>MRS NAOMI SPRY - wife</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>201</u> <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not Where at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>BELDEN K. NEAL</u> MD EXAMINER'S NAME (Type) <u>BELDEN K. NEAL</u> MD 22. DATE SIGNED <u>JUNE 17 1967</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>JUNE 20 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Belleville Park</u> 23d. LOCATION (City or town) (County) (State) <u>Bethesda Prince Georges Md.</u>		24. FUNERAL DIRECTOR <u>Northwest Funeral Home</u> 25. ADDRESS <u>254 Carroll Street N.W. Washington, D.C. 20012</u> 25a. REC'D BY REGISTRAR <u>JUN 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08478

08484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2213 Shorefield Rd.</u> <u>Appt. 264</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>A.</u> Last <u>STEWART</u>		4 DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/07</u>
9 AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11 BIRTHPLACE (County & State or foreign country) <u>York, Pa</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Kauffman</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Fisher</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>	
16 SOCIAL SECURITY NO <u> </u>		17 INFORMANT <u>Lawrence Stewart - Husband</u> Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1533</u> DUE TO <u>hepatic failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Massive liver metastasis</u> (c) <u>Carcinoma sigmoid</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6/10/67</u> to <u>6/20/67</u> that (I) (we) last saw the deceased alive on <u>6/20/67</u> 19 <u> </u> , and that death occurred at <u>6:20 PM</u> from causes and on the date stated above	
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD C. MYERS</u>		22d. ADDRESS <u>8512 OLD GEORGETOWN RD BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE MO. MD</u>	
24. FUNERAL DIRECTOR <u>SALAMONE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>JUL 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

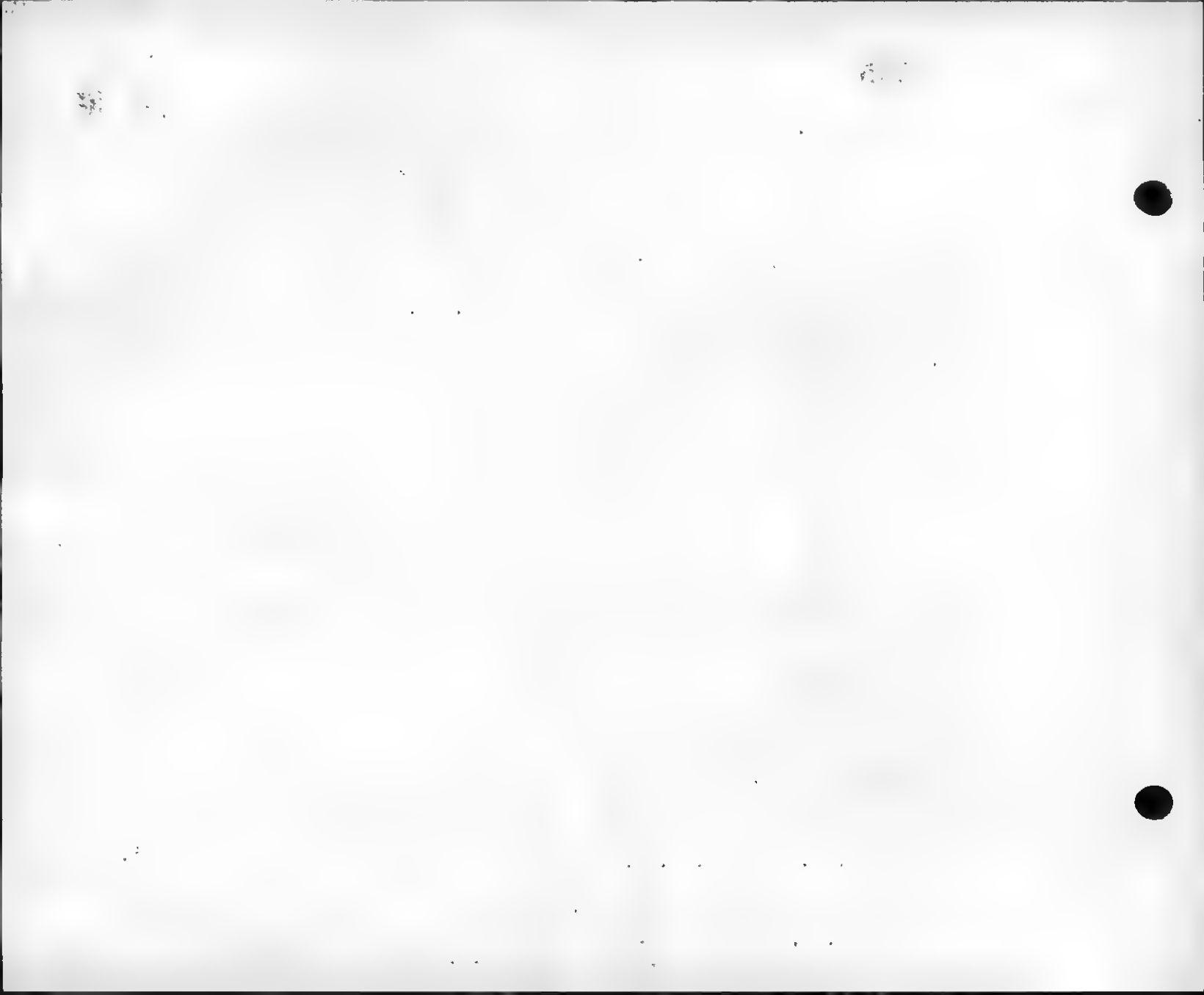
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08485

CERTIFICATE OF DEATH

08479

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Wisconsin b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 1921 Northwestern	
3. NAME OF DECEASED (Type or print) First Gordon Middle Wayne Last STOFLET		4. DATE OF DEATH Month June Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1946
9. AGE (In years last birthday) yrs 20		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Madison, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gordon Stoflet		14. MOTHER'S MAIDEN NAME Virginia Ginger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe craniocerebral injury due to missile DUE TO Severe craniocerebral injury due to missile Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Enemy Action	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 13, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Viet Nam		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 16, 1967 , to June 29, 1967 , that (I) (we) last saw the deceased alive on June 29, 1967 , and that death occurred at 205A M. from causes and on the date stated above.			
22a. SIGNATURE F. L. EDEIMAN		22b. DATE SIGNED 6/30/67	
22c. PHYSICIAN'S NAME (Type) F. L. EDEIMAN, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-1-1967	
23c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery		23d. LOCATION (City or Town) (County) (State) Madison Wisconsin	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N. W. Washington, D.C.		25a. REC'D BY REGISTRAR JUL 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08486

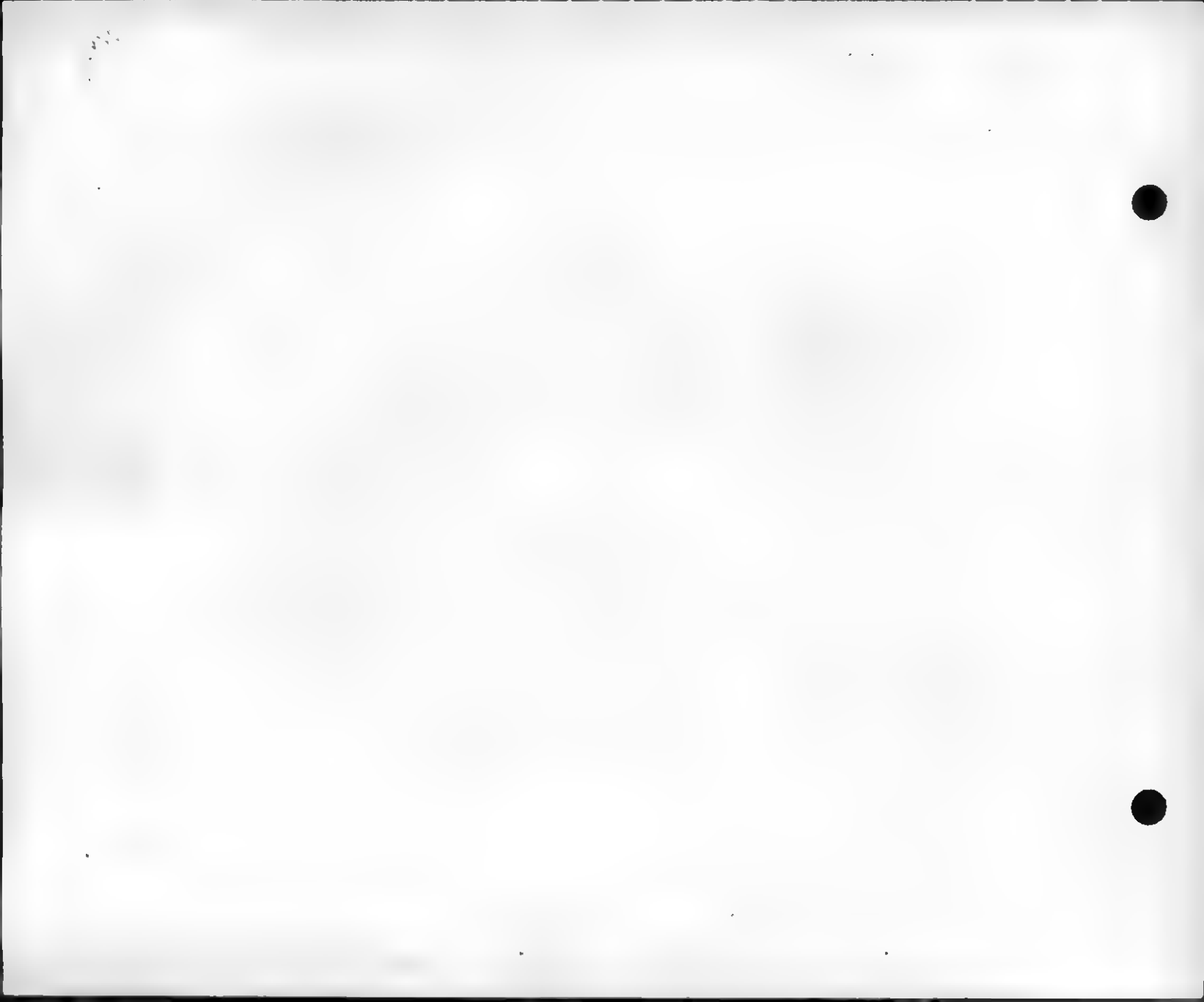
CERTIFICATE OF DEATH

08480

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>3800 Shephard Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Leroy</u> Last <u>Stoner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/95</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months <u>71</u> Days <u>13</u> Hours <u>13</u> M.in.	IF UNDER 24 HRS M.in.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Maurice Stoner</u>			14. MOTHER'S MAIDEN NAME <u>Reynolds</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. I (Army)</u>			16. SOCIAL SECURITY NO. <u>216-44-889</u>		17. INFORMANT <u>Hospital Records, Wash. San. & Hosp.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Metastatic carcinoma of bladder</u> (c) <u>Carcinoma of bladder</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1964</u> to <u>6/13</u> , 1967, that (I) (we) last saw the deceased alive on <u>6/12</u> , 1967, and that death occurred at <u>10</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur J. Wilets</u>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Wilets</u>			22d. ADDRESS <u>1015 Spring st Silver Spring Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor 'ro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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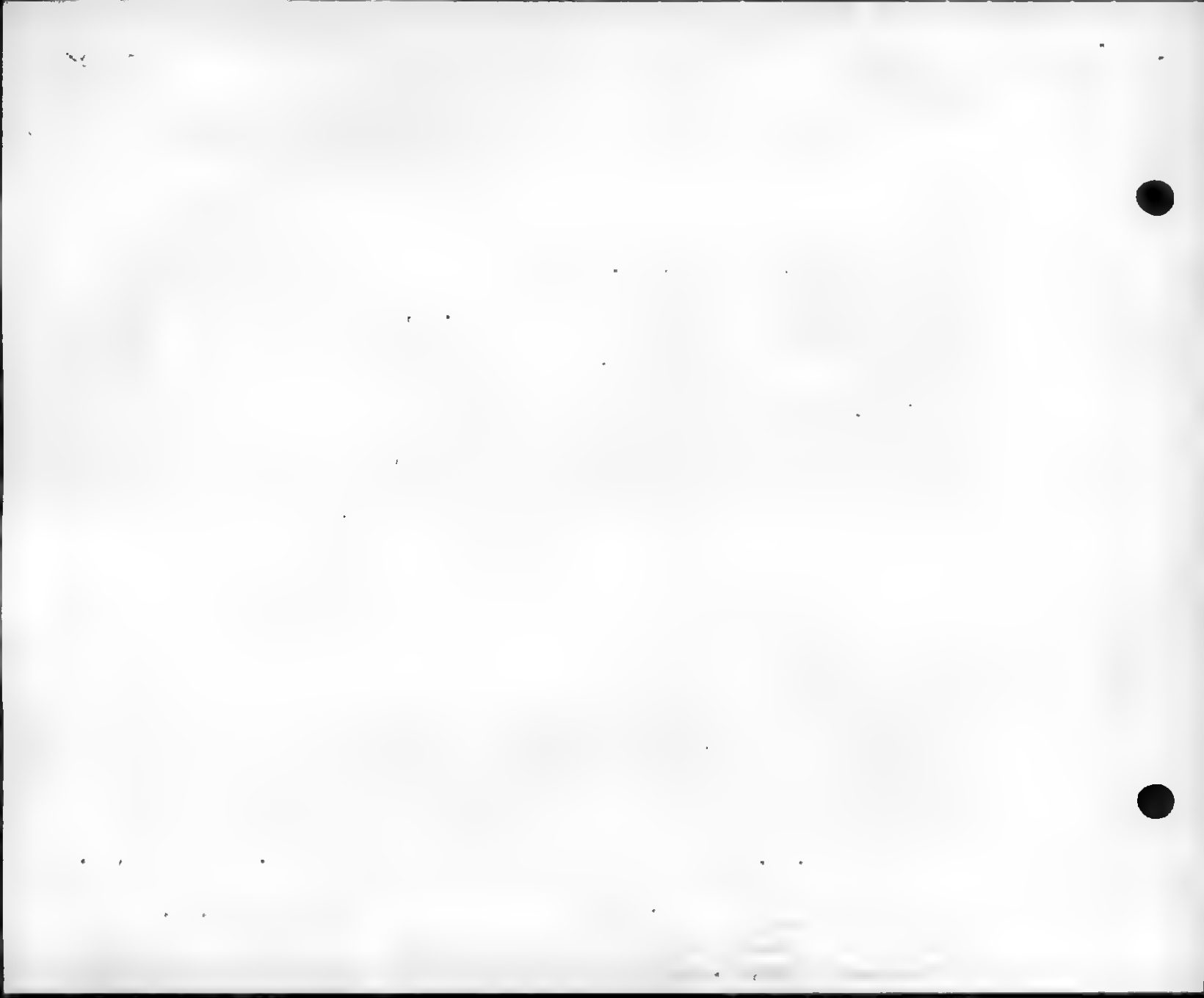
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08487

CERTIFICATE OF DEATH

08481

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 10700 Swain Lock Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT LEE SWAIN, Sr.				4. DATE OF DEATH June 3, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1905	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jessie A. Swain			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. 579-07-0028		17. INFORMANT Address Virginia M. Swain-Item # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 to 6-3, 1967 , that (I) (we) last saw the deceased alive on 6-3, 1967 , and that death occurred at 4 PM , from causes and on the date stated above.							
22a. SIGNATURE Donald L. Bucy			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/3/67	
22c. PHYSICIAN'S NAME (Type) D. L. Bucy			22d. ADDRESS 809 Viers Mill Rd., Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/67		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City or Town) (County) (State) Beallsville, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR JUN 8 1967		25b. REGISTRAR'S SIGNATURE James Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 1 1/2 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		d. STREET ADDRESS 1914 Fox St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva Belle Sweeney		First Eva		Middle Belle		Last Sweeney		4. DATE OF DEATH 6/6/1967		Month 6		Day 6	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/29/1890		9. AGE (In years last birthday) 76 7/8 yrs.		IF UNDER 1 YEAR Months 7		IF UNDER 24 HRS. Days 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Marmaduke		14. MOTHER'S MAIDEN NAME Alice Reed		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 217-52-6495		17. INFORMANT George W. Sweeney		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency DUE TO (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to June , 19 67 , that (I) (we) last saw the deceased alive on June 6 , 19 67 , and that death occurred at 2:27 PM , from the causes and on the date stated above.		22a. SIGNATURE Bernard A. Fitzgerald, M.D.		22b. DATE SIGNED 6-6-67		22c. PHYSICIAN'S NAME (Type) Bernard Fitzgerald, MD	
22d. ADDRESS 217 University Blvd., E., S. S., Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Alexandria, Virginia		24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR JUN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 2174 Georgia Avenue Silver Spring, Md.		25d. DATE JUN 12 1967		25e. SIGNATURE Charles Judge		25f. ADDRESS 2174 Georgia Avenue Silver Spring, Md.		25g. DATE JUN 12 1967		25h. SIGNATURE Charles Judge	

6. 1. 1964

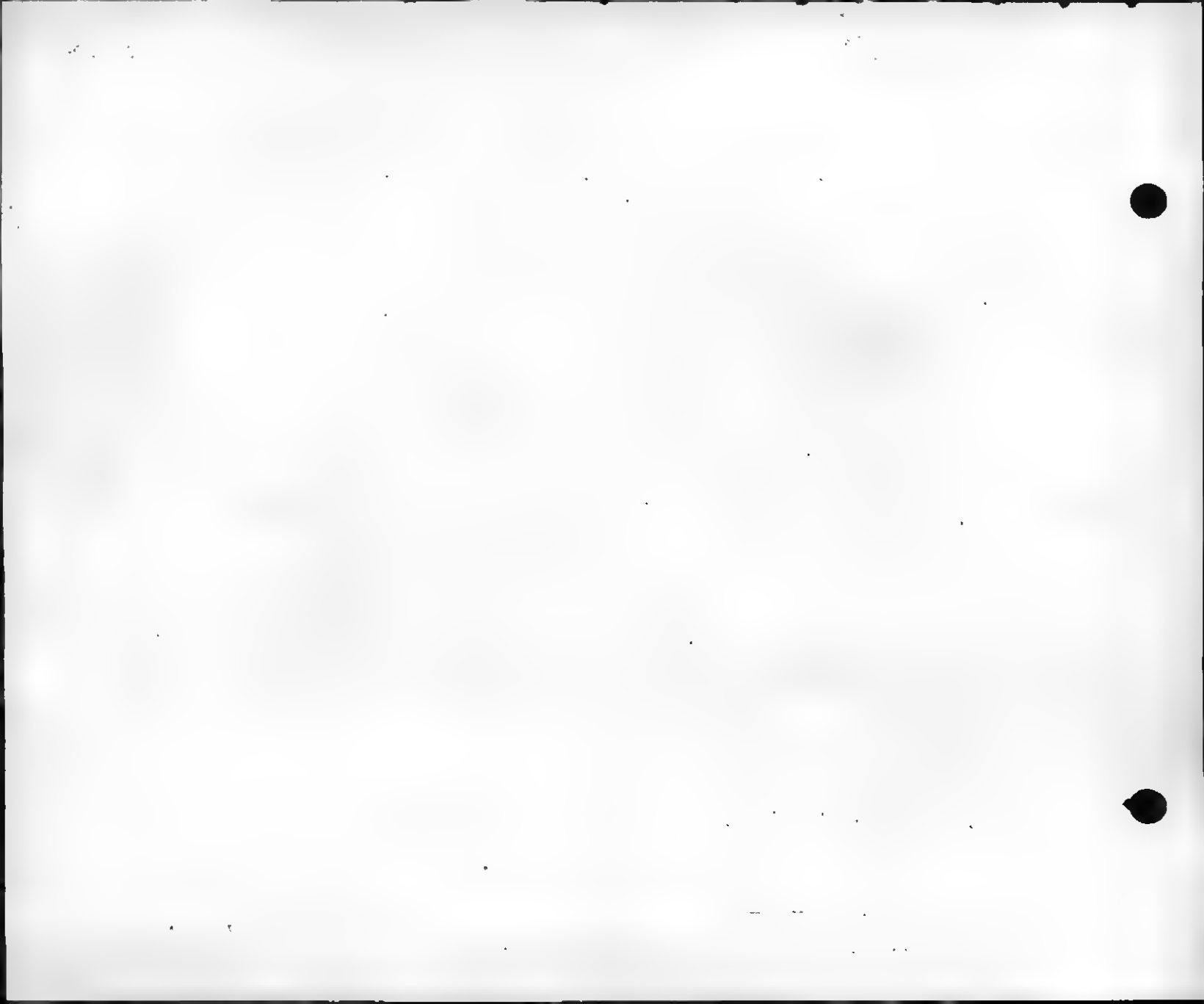


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08483		08483	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>1st of LIFE TIME</u>		d. STREET ADDRESS <u>2417-EVANS DRIVE</u> <u>FOREST GREEN RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOPE CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE C TALBERT</u>		4. DATE DEATH <u>6-9</u> 19 <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-88</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		9b. AGE (in years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS.	
10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FREDERICK - MUNCHMEYER</u>	
14. MOTHER'S MAIDEN NAME <u>FRANCES - STEVENSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>579-48-3906</u>		17. INFORMANT <u>JANICE HERDA</u> Address <u>2417 EVANS DR. SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> DUE TO (b) <u>same</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>same</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of Rt leg - amputated</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 22, 1967</u> to <u>June 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 9, 1967</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. T. Marcus</u>		22b. DATE SIGNED <u>6/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM MARCUS</u>		22d. ADDRESS <u>10620 BA. AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6-14-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Hawler's Sons</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1967</u>	
ADDRESS <u>5730 WISC AVE WASH DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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Cleared by Medical Examiner

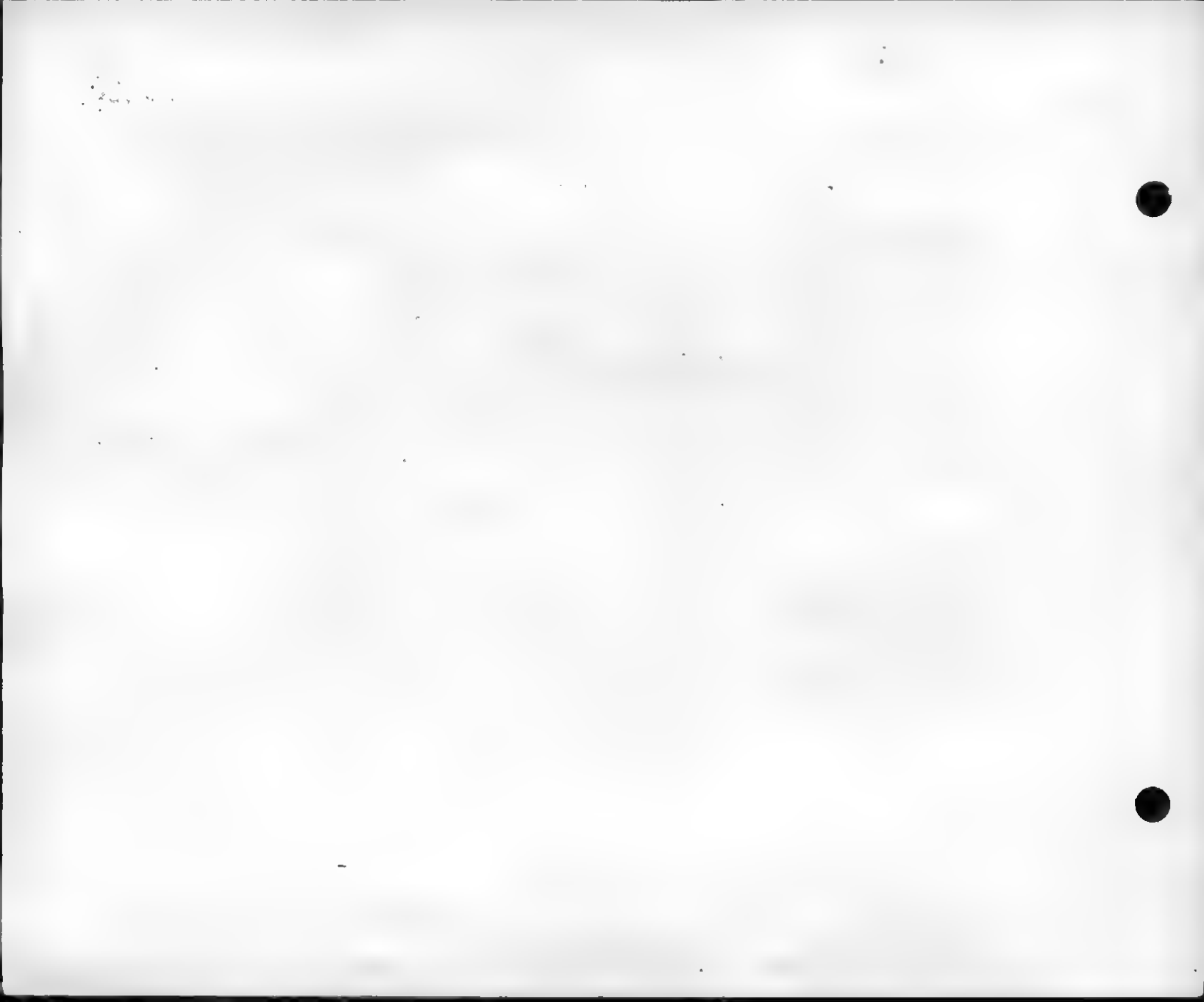
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08480

CERTIFICATE OF DEATH

08484

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5001 Russett Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Irving Taylor		4. DATE OF DEATH Month June Day 20 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1926
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptroller Accountant		10b. KIND OF BUSINESS OR INDUSTRY Sidwell Friends School	9. AGE (In years last birthday) 41 yrs.
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Irving Taylor		14. MOTHER'S MAIDEN NAME Eleanor Sullivan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII & Korean		16. SOCIAL SECURITY NO. 133-16-5653	
17. INFORMANT Josephine R. Taylor		Address 5001 Russett Road Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of larynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 161X (c) 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1967 to 6/14, 1967 , that (I) (we) last saw the deceased alive on 6/14, 1967 , and that death occurred at 9:55 PM , from causes and on the date stated above			
22a. SIGNATURE Louis K. Alpert		22b. DATE SIGNED 6-21-67	
22c. PHYSICIAN'S NAME (Type) Louis K. Alpert, M.D.		22d. ADDRESS 2300 K ST. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR John B. Thomas, Jr. 434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR June 20 1967	
		25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey	



CERTIFICATE OF DEATH

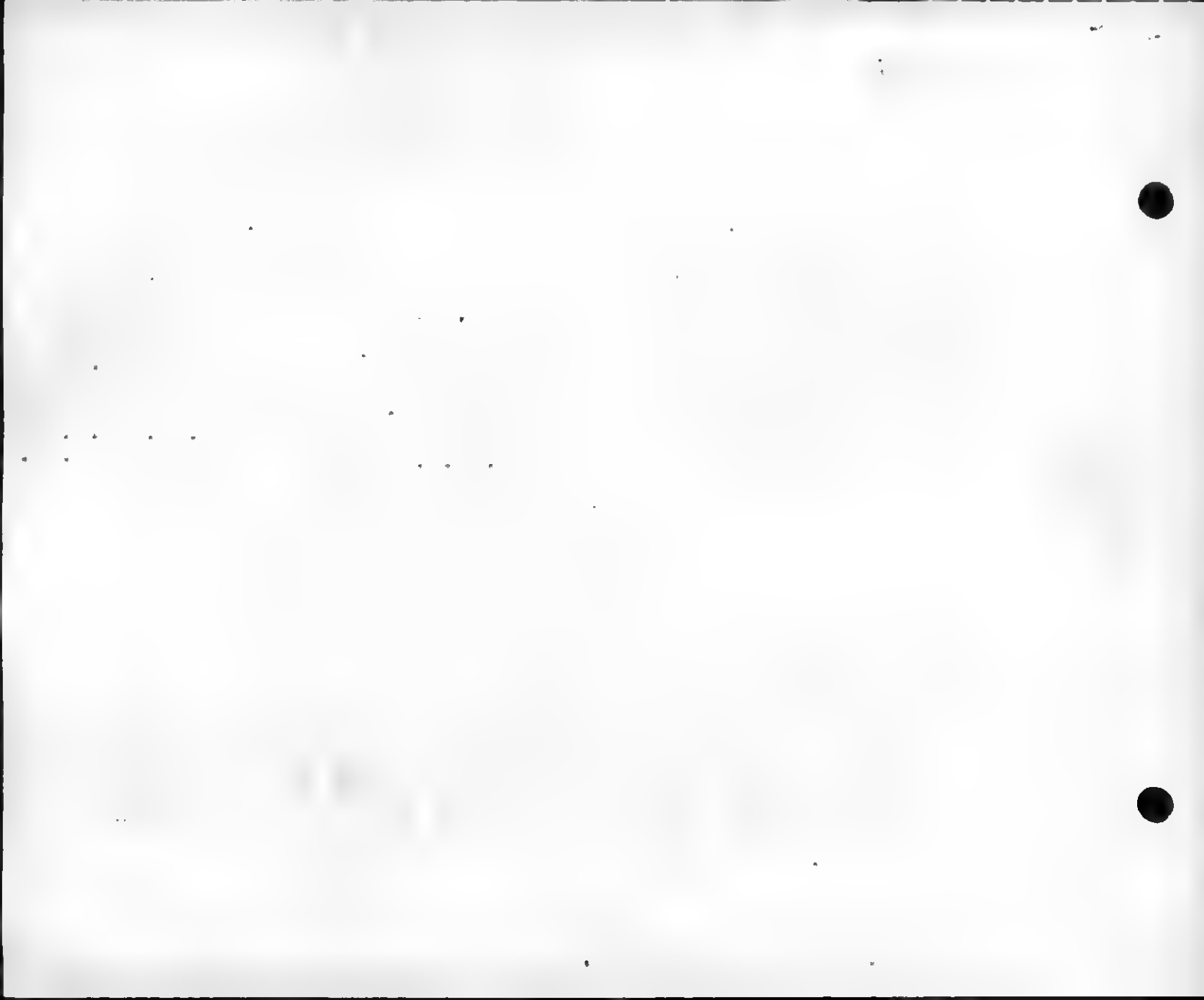
08492

08486

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE Maryland b COUNTY Montgomery			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c LENGTH OF STAY IN 1b years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5515 Johnson Ave.				d. STREET ADDRESS 5515 Johnson Ave.		e IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) VIRGINIA B. THAMES First Middle Last				4 DATE OF DEATH June 13th 1967 Month Day Year			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 5, 1899	
9 AGE (In years last birthday) 67		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Powhatan Bouldin			
14. MOTHER'S MAIDEN NAME Mary E. Moir				15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Neice Mrs. W.G. Clayton 2912 N. St., N.W. Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. 4201 IMMEDIATE CAUSE (a) Acute coronary failure DUE TO Cond itions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis of unknown etiology DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1939 , to June 13, 1967 , that (I) was last saw the deceased alive on June 8th 1967 , and that death occurred at 4:34 P.M. from causes and on the date stated above.			
22a SIGNATURE W. LeRoy Dunn				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 6-13-67	
22c PHYSICIAN'S NAME (Type) W. LeRoy Dunn				22d ADDRESS 5508 Park Road Chevy Chase, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6-16-67		23c NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a REC'D BY REGISTRAR DATE JUN 22 1967		25b. REGISTRAR'S SIGNATURE John A. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



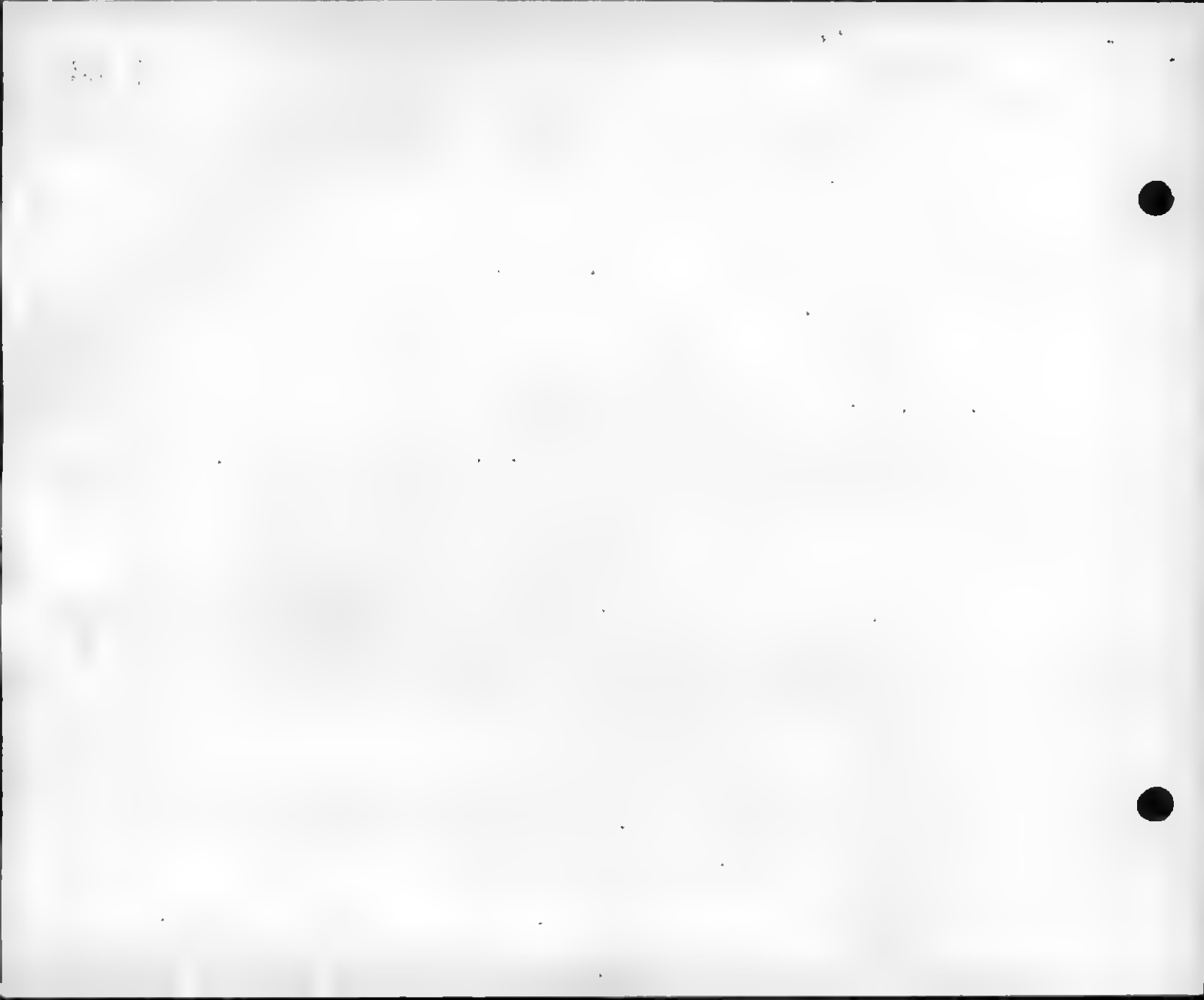
08493

CERTIFICATE OF DEATH

08487

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Texas Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville/ Austin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 421 Brady Lane Potomac Valley Nursing Home	
3 NAME OF DECEASED (Type or print) Howard R. Thomas		4 DATE OF DEATH Month June Day 30 Year 19 67	
5 SEX Male	6. COLOR OR RACE W.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 12, 1887
9 AGE (n years) 79 (lost birth) yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John B. Thomas		14. MOTHER'S MAIDEN NAME Frances Rice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 263-62-0653-T	
17. INFORMANT J. L. Thomas- Rockville, Md.		Address 13900 Glen Mill Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2a. IMMEDIATE CAUSE (a) cerebrovascular thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholecystitis and cholelithiasis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10, 1965 , to 6-30 1967 that (I) (we) lost saw the deceased alive on 6-29 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE S. N. Jones / Dr. Jones		22b. DATE SIGNED 6-30-67	
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22d. ADDRESS 889 Views Mill Rd Rockville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7/1/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Prince George Co., Maryland
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR JUL 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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20 M 1/66

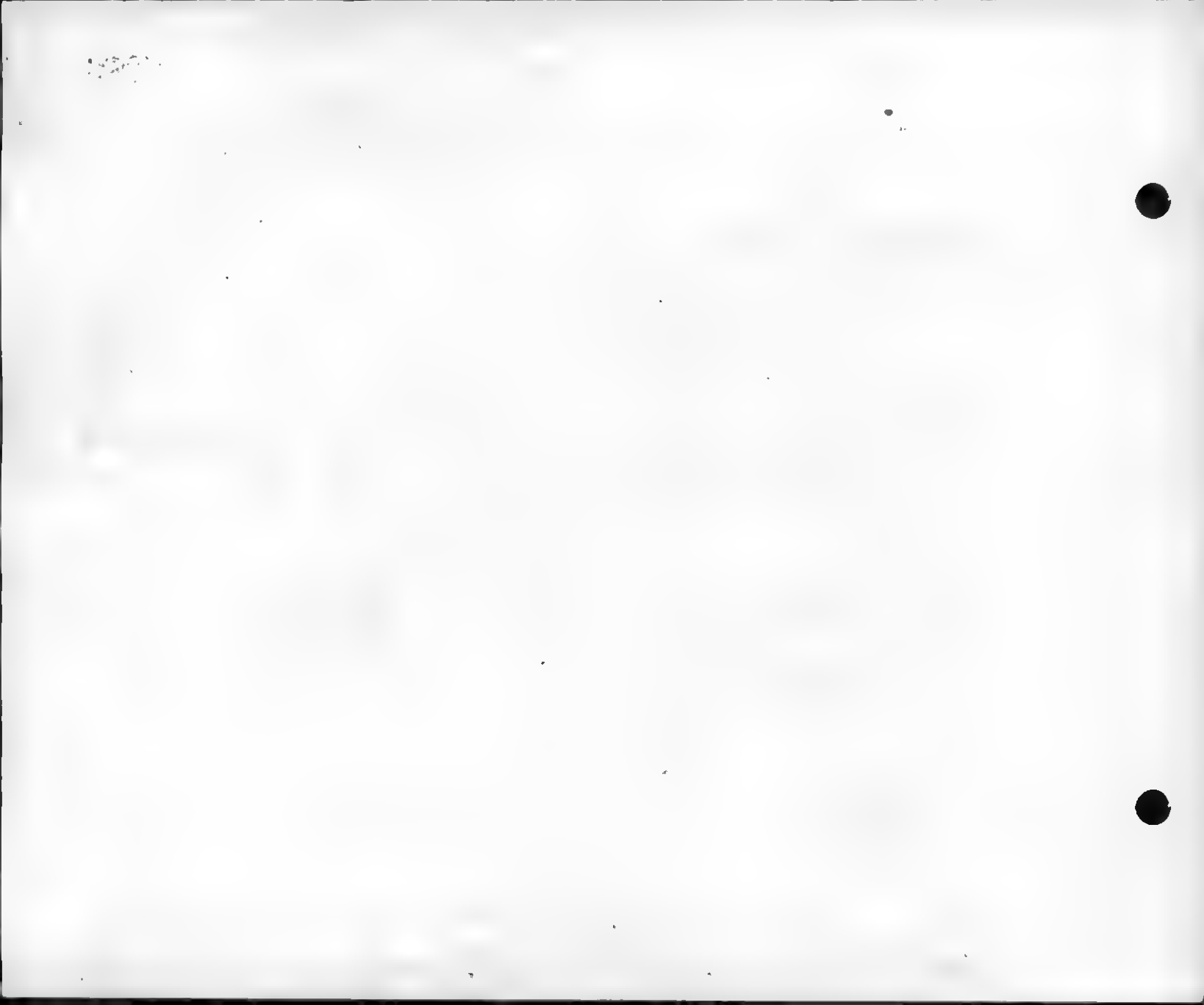
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08494

CERTIFICATE OF DEATH

08488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>				d. STREET ADDRESS <u>1132 Arcola Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Frances</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/4/1878</u>	
9. AGE (In years last birthday) <u>89</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Barnes</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Coupard</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO <u>None</u>				17. INFORMANT <u>Dorsey L. Thompson</u> Address <u>1132 Arcola Avenue Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease, Cong. Failure</u> 4:00 P.M. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>as above</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>seventy yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>June 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> , 19 <u>67</u> , and that death occurred at <u>3:10</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Bufalino</u>				22b. DATE SIGNED <u>June 19, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. C. BUFALINO, M.D.</u>				22d. ADDRESS <u>1429 University Blvd. W. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>	
24. FUNERAL DIRECTOR <u>E. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JUN 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08495

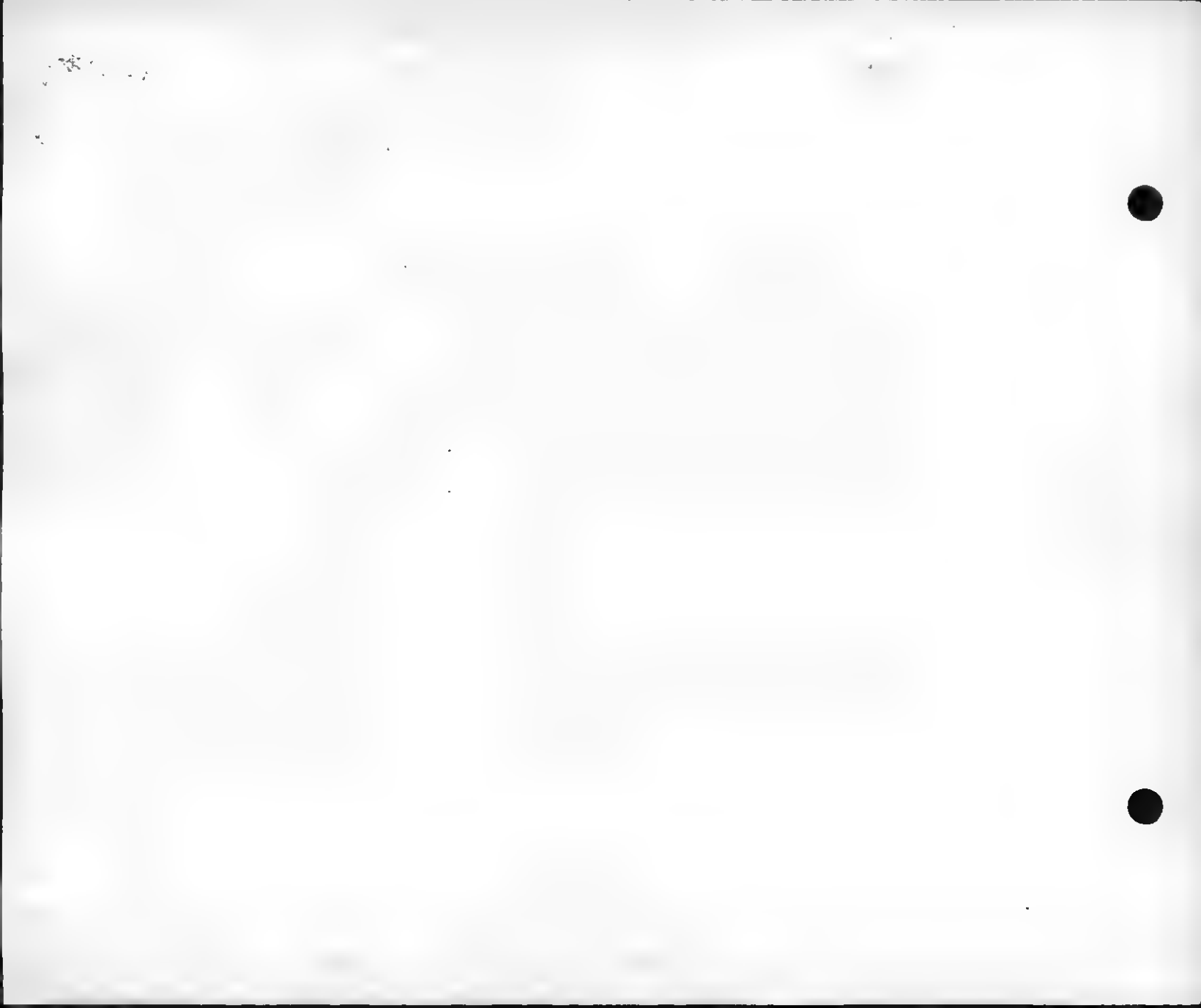
CERTIFICATE OF DEATH

08433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY IN IL <u>1 mo 10 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Inn</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>G</u> Last <u>TOOL SR.</u>		4 DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 5, 1877</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Scientist</u>	9 AGE (in years last birthday) <u>89</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Jasper Co. IOWA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Tool</u>		14 MOTHER'S MAIDEN NAME <u>SALINA E Oldham</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16 SOCIAL SECURITY NO <u>220-44-1390</u>	
17 INFORMANT <u>Mrs. Arthur Tool, Jr. (same as #2)</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4001</u> <u>neurogenic acute Cong Failure</u> DUE TO <u>Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Ascaris</u> DUE TO <u>Ascaris</u> (c) <u>Ascaris</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Surgery Removal leg because of gangrene</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>67</u> to <u>June</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>67</u> , and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Russell C. Bufalino</u>		22b. DATE SIGNED <u>6-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>		22d. ADDRESS <u>1424 University Blvd W. S.S. Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>June 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Monroe Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Fairview Twp. Jasper Co. Ind</u>
24 FUNERAL DIRECTOR <u>Arthur Hatter, 254 Carroll St NW, Wash DC</u>		25a REC'D BY REGISTRAR DATE <u>JUN 6 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

38496

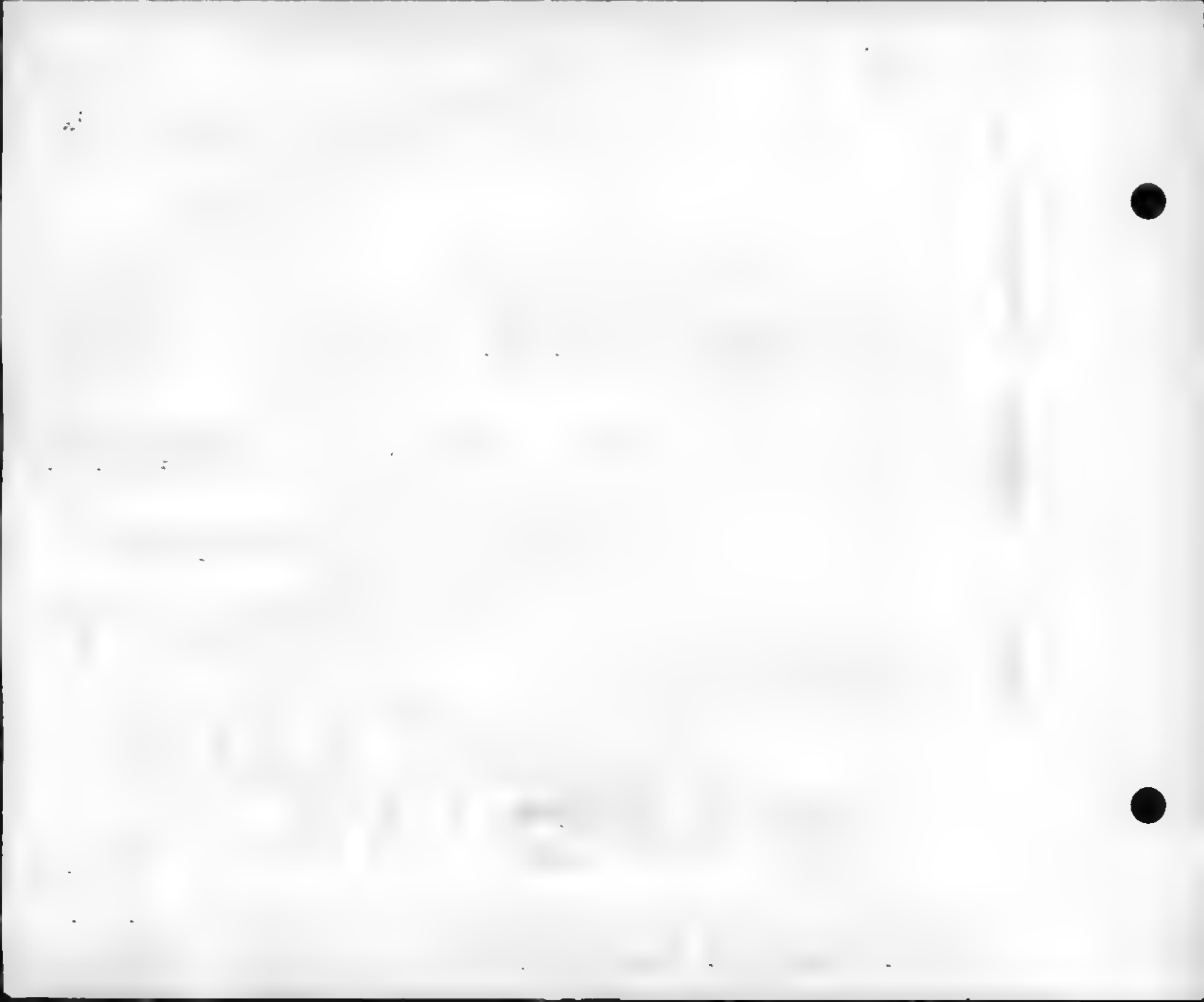
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Cleared Medical Examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>7115 Woodland Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Lee</u> Last <u>Towne</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/06</u>	9. AGE (in years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer Reader</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William E. Towne</u>			
14. MOTHER'S MAIDEN NAME <u>Pearl Reese</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>			
16. SOCIAL SECURITY NO. <u>067-01-1899</u>				17. INFORMANT <u>Pearl E. Towne</u> Address <u>7115 Woodland Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH Hours <u> </u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Severe arteriosclerotic heart disease.</u> DUE TO (c) <u>With acute coronary insufficiency</u>							years <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>65</u> , to <u>June 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 16</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>				22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Harner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

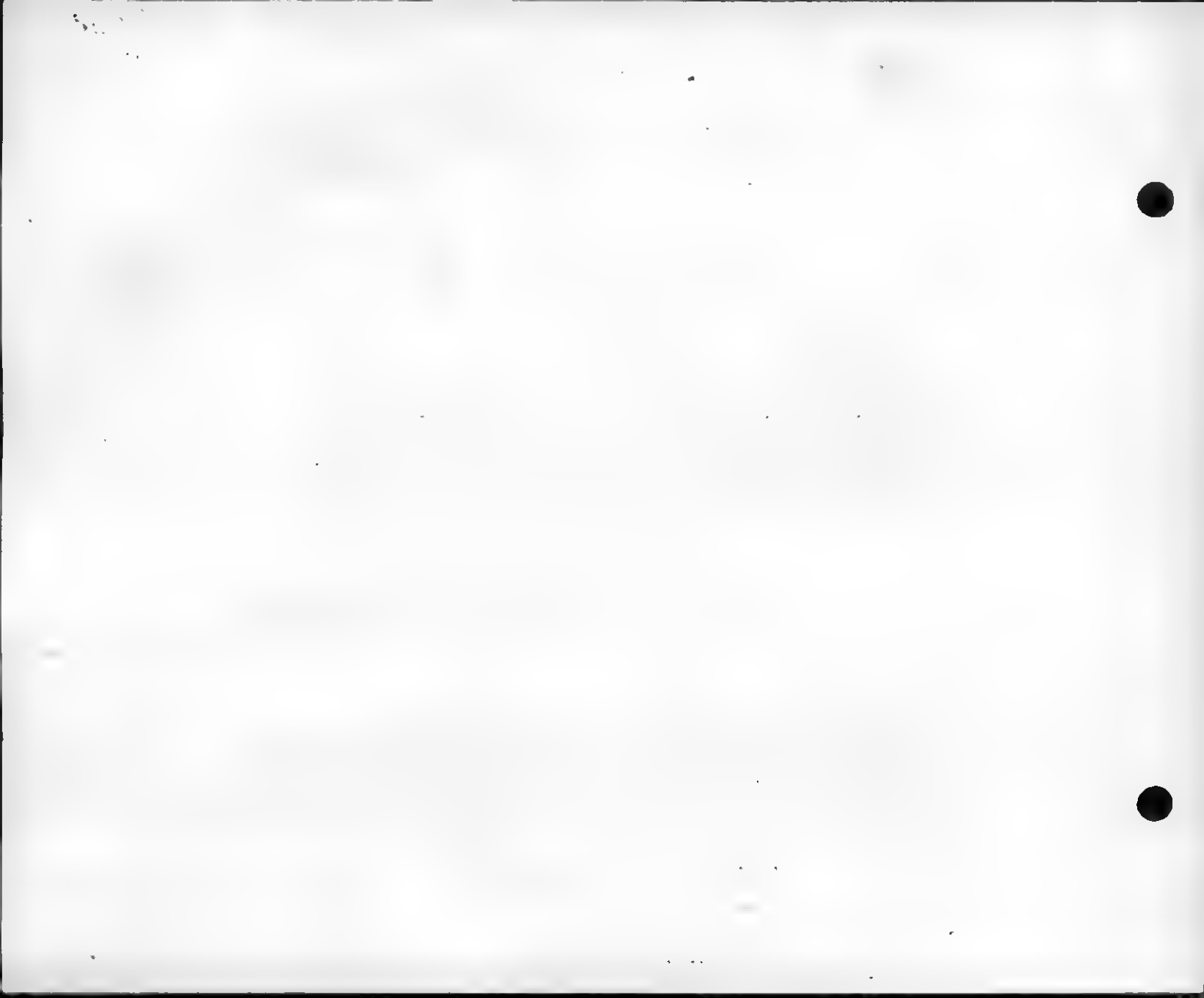
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08497

CERTIFICATE OF DEATH

08491

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 6 hrs 5 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp LeJeune		d. STREET ADDRESS MOQ 2509	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Christopher Thomas TOWNSEND		4 DATE OF DEATH Month Day Year June 27 19 67	
5 SEX Male	6 COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 March 1967
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Camp LeJeune, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas A. Townsend		14. MOTHER'S MAIDEN NAME Anne Taubitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Thomas A. Townsend, MOQ 2509, Camp LeJeune		Address N.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from June 26, 1967, to June 27, 1967, that (s) (we) last saw the deceased alive on June 27, 1967, and that death occurred at 505A M. from causes and on the date stated above.			
22a. SIGNATURE LCDR A. E. TOMPKINS		22b. DATE SIGNED June 27, 1967	
22c. PHYSICIAN'S NAME (Type) LCDR A. E. TOMPKINS, LCDR MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-29-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR DATE JUN 29 1967	
		25b. REGISTRAR'S SIGNATURE	



Cleared with Coroner
R.B.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08498

CERTIFICATE OF DEATH

08492

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 25 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 7802 Wildwood Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. and Hsp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Otis Carroll Trimble		4. DATE OF DEATH Month Day Year 6 5 19 67	
5. SEX Male	6. COLOR OR RACE Wht	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-17-96
9 AGE (in years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exchange officer		10b. KIND OF BUSINESS OR INDUSTRY State Dept.	
11 BIRTHPLACE (County & State, or foreign country) Arkansas		12 CITIZEN OF WHAT COUNTRY? U S.A.	
13 FATHER'S NAME Mathew Allen Trimble		14. MOTHER'S MAIDEN NAME Annie McFarland	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1		16 SOCIAL SECURITY NO 578-32-0090	
17 INFORMANT Eva Trimble		Address 7802 Wildwood Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease DUE TO (c) 3-4 mos.		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20, 1967 , to June 5, 1967 , that (I) (we) last saw the deceased alive on June 2, 1967 , and that death occurred at 11:35 PM from causes and on the date stated above.			
22a. SIGNATURE Russell B. Arnold M.D.		22b DATE SIGNED June 5, 1967	
22c PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d ADDRESS 1106 Spring Street, Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Inter-burial		23b DATE THEREOF June 9, 1967	
23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d LOCATION (City or Town) (County) (State) Green Forest, Arkansas	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR JUN 12 1967	
ADDRESS 8434 Georgia Avenue		25b. REGISTRAR'S SIGNATURE John Charles Judge	



08493

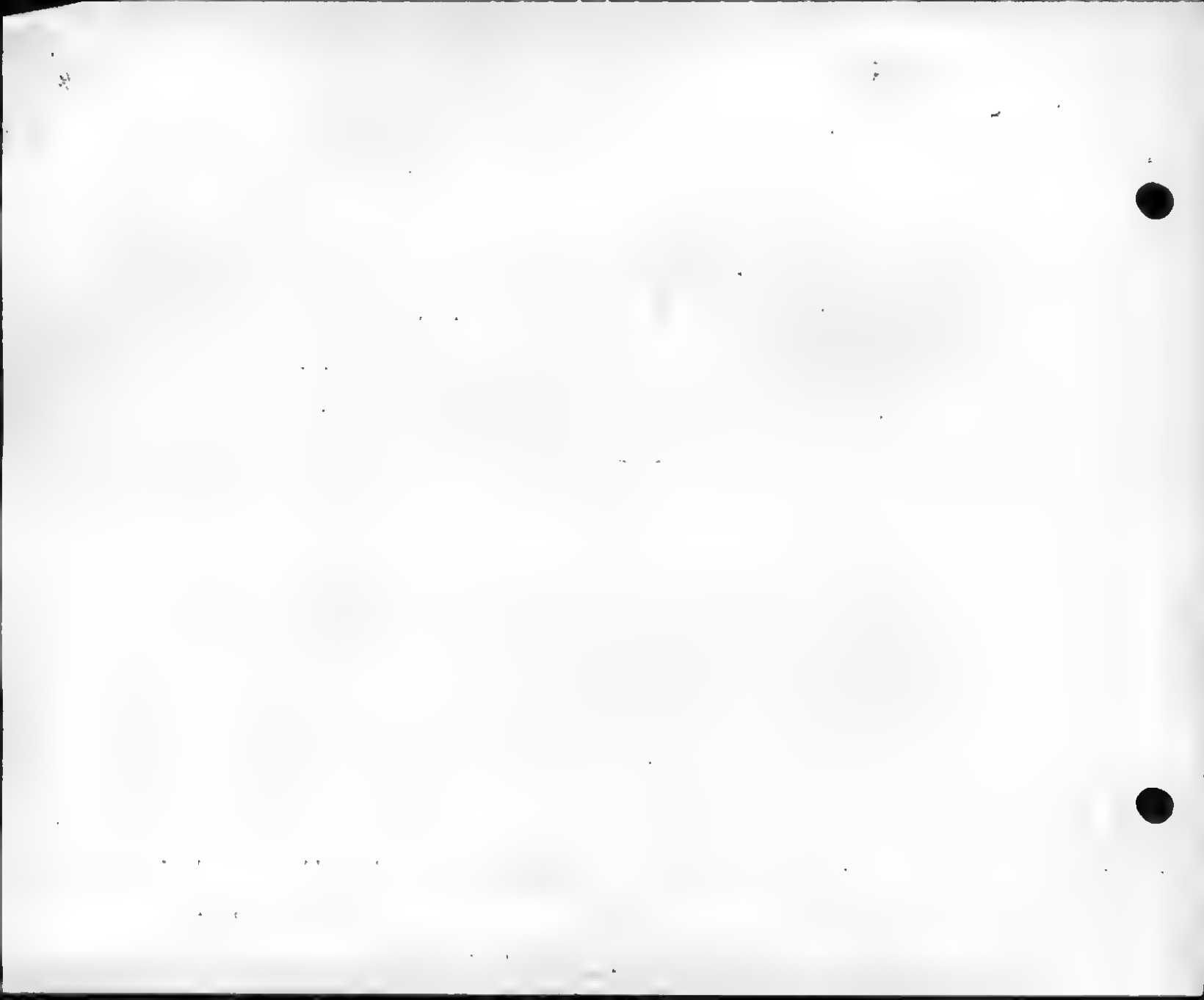
CERTIFICATE OF DEATH

08493

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b Rockville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Nursing Home		d. STREET ADDRESS 1214 Gladstone Drive	
3 NAME OF DECEASED (Type or print) Luther A. Trunnell		4 DATE OF DEATH June 7, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1887
9. AGE (in years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John A. Trunnell		14. MOTHER'S MAIDEN NAME Roberta Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 577-16-4972	
17. INFORMANT Agnes C. Trunnell-Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 551X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Prostate.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from May 12, 1967 to June 7, 1967 , that (I) was last saw the deceased alive on June 6, 1967 , and that death occurred at 5:30 AM from causes and on the date stated above.			
22a. SIGNATURE J. Blaine Fitzgerald		22b. DATE SIGNED 6/7/67.	
22c. PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald		22d. ADDRESS 8218 Wis. Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/67	
23c. NAME OF CEMETERY OR CREMATORY Rockville		23d. LOCAT ON (City or Town) (County) (State) Rockville, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

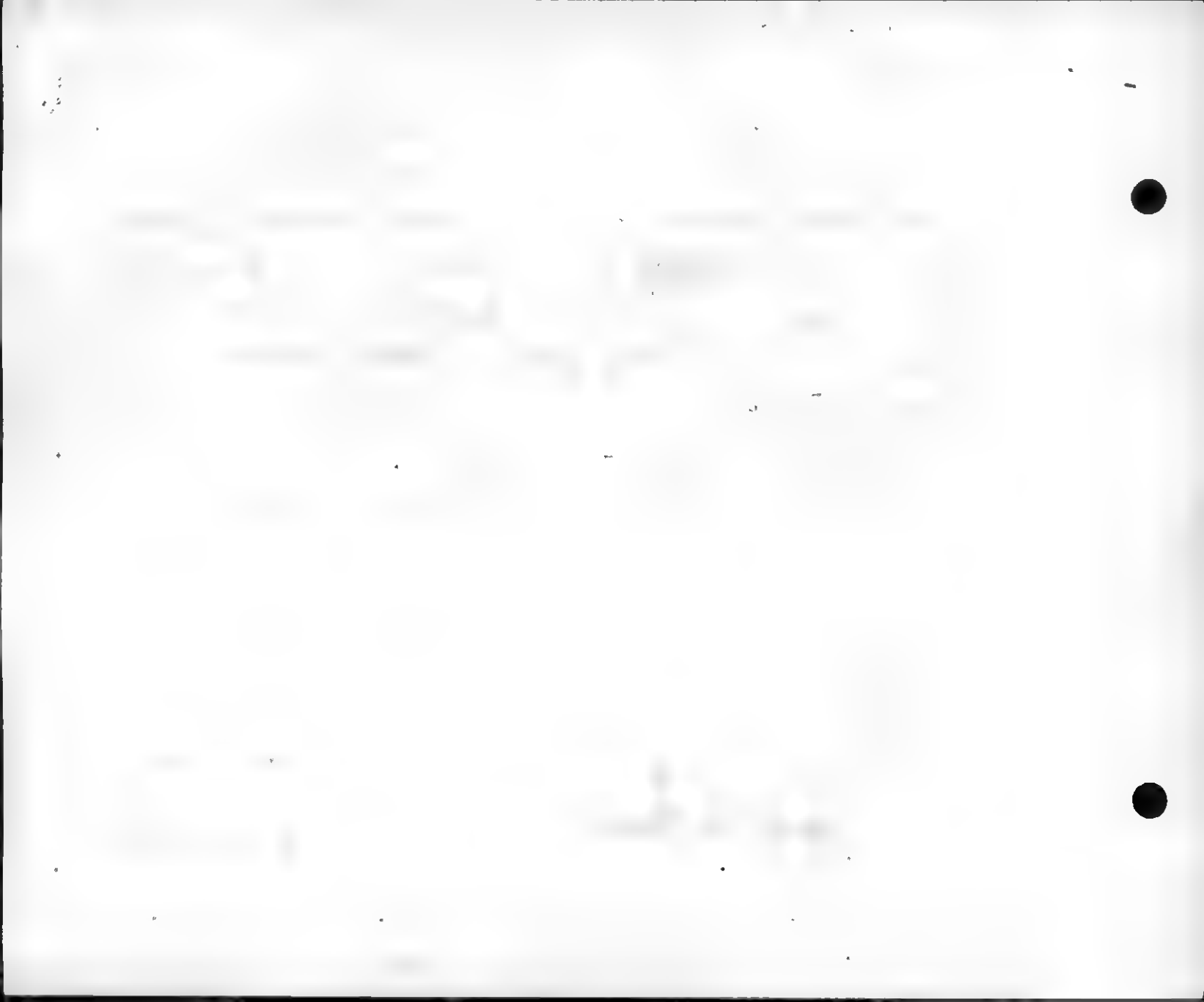
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08494

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Montgomery		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mill Creek Towne 6 Mo.		c LENGTH OF STAY IN TB		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mill Creek Towne, Derwood	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 17801 Vineyard Street			d STREET ADDRESS 17801 Vineyard Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Rudolph J Middle TURCO Last TURCO			4 DATE OF DEATH Month June Day 13 Year 1967		
5 SEX M.	6 COLOR OR RACE W.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug 17, 1910		9 AGE (In years, months, days, hours, minutes) 56
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Section Chief - GPO		10b KIND OF BUSINESS OR INDUSTRY Printing Gov.		11 BIRTHPLACE (State or foreign country) Washington D.C.	
13 FATHER'S NAME Louis TURCO -			14 MOTHER'S MAIDEN NAME Camilla DePaola		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO 577-40-0965		17 INFORMANT Wife Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, coronary thrombosis, coronary arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) 4201 DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 12 hr. - years.
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f CITY OR TOWN (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL		M.D.		22. DATE SIGNED 6/14/67 Address (Street, city, town or county) Bethesda, Md.	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 6-17-67		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a REC'D BY REGISTRAR JUN 16 1967	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

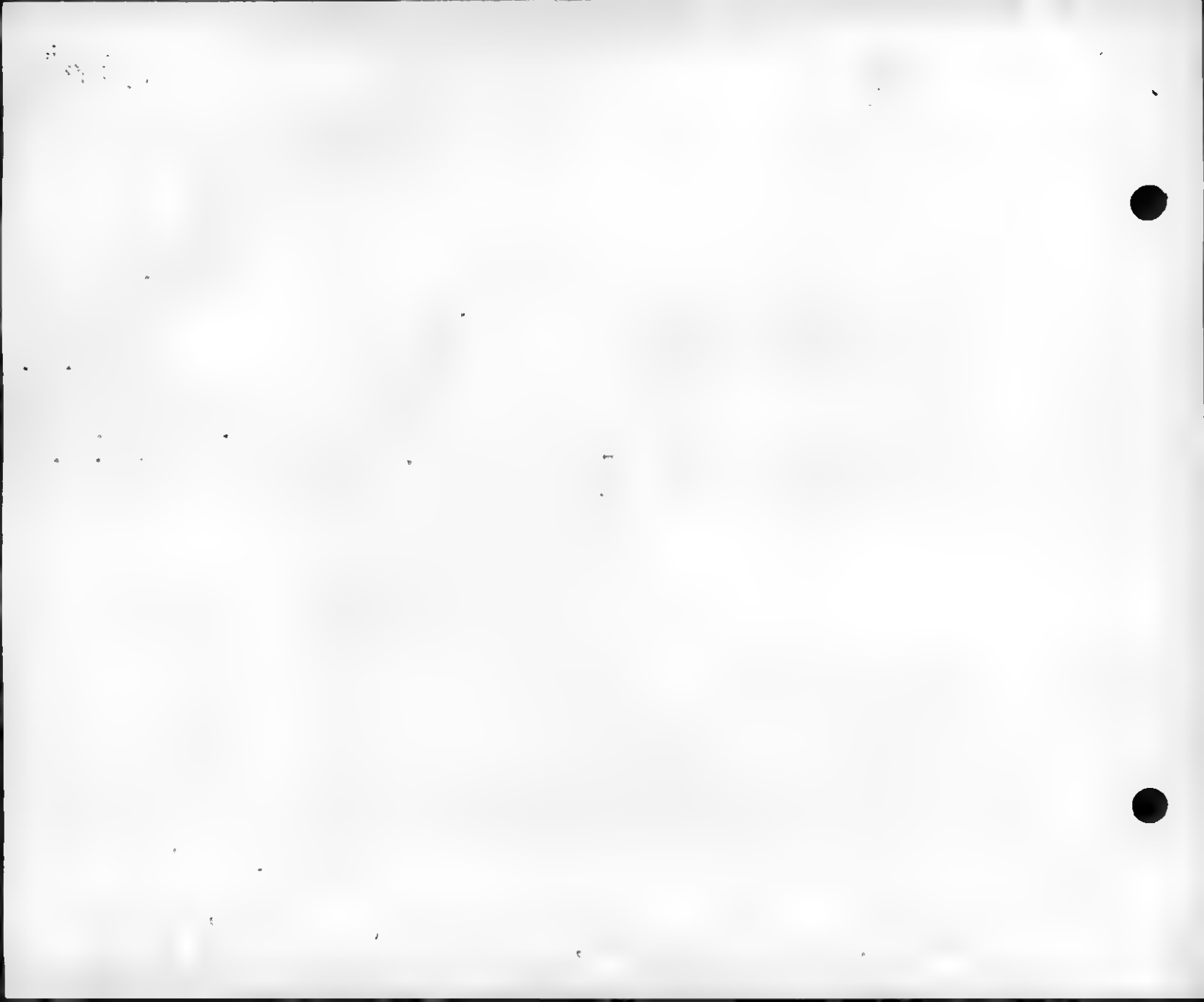
08501

CERTIFICATE OF DEATH

08495

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 5 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium		e. STREET ADDRESS 9704 Bexhill Drive	
3 NAME OF DECEASED (Type or print) ALEXANDER Frank VAN ROSSUM		4. DATE OF DEATH Month June 11, Day 19 Year 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1877
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11 BIRTHPLACE (County & State or foreign country) Belgium	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECUR. TY. NO. 082-0548664	
17. INFORMANT Wife		18. ADDRESS 605-W 13th St. NYC, N. Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CIRCULATORY COLLAPSE DUE TO A. S. H. D. DUE TO generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH MINUS 5+ YRS 10+ YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) D N A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 1967 to 6/11, 1967 , that (I) (we) last saw the deceased alive on 6/9 1967 , and that death occurred at 11:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Charles Saverese MD		22b. DATE SIGNED 6-12-67	
22c. PHYSICIAN'S NAME (Type) CHARLES SAVERESE		22d. ADDRESS 11125 Rockville, Pike Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 6-15-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08502

CERTIFICATE OF DEATH

08496

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 21 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 3926 Suitland Road	
3. NAME OF DECEASED (Type or print) Baby Boy "A"		4. DATE OF DEATH Month June Day 1 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1967
9. AGE (In years, last birthday) 1 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roger L. Waddell		14. MOTHER'S MAIDEN NAME Cheryl Crider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Suitland, Roger L. Waddell		Address Maryland 3926 Suitland Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity; Atelectasis, lung DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from June 1, 19 67 to June 1, 19 67 , that (2) (we) last saw the deceased alive on June 1, 19 67 , and that death occurred at 755 M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. E. Winker</i>		22b. DATE SIGNED June 7, 1967	
22c. PHYSICIAN'S NAME (Type) J. E. WINKER, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Transfer	2 June 1967	Naval Medical School	NNMC Bethesda, Md.
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>
		DATE JUN 12 1967	

FR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

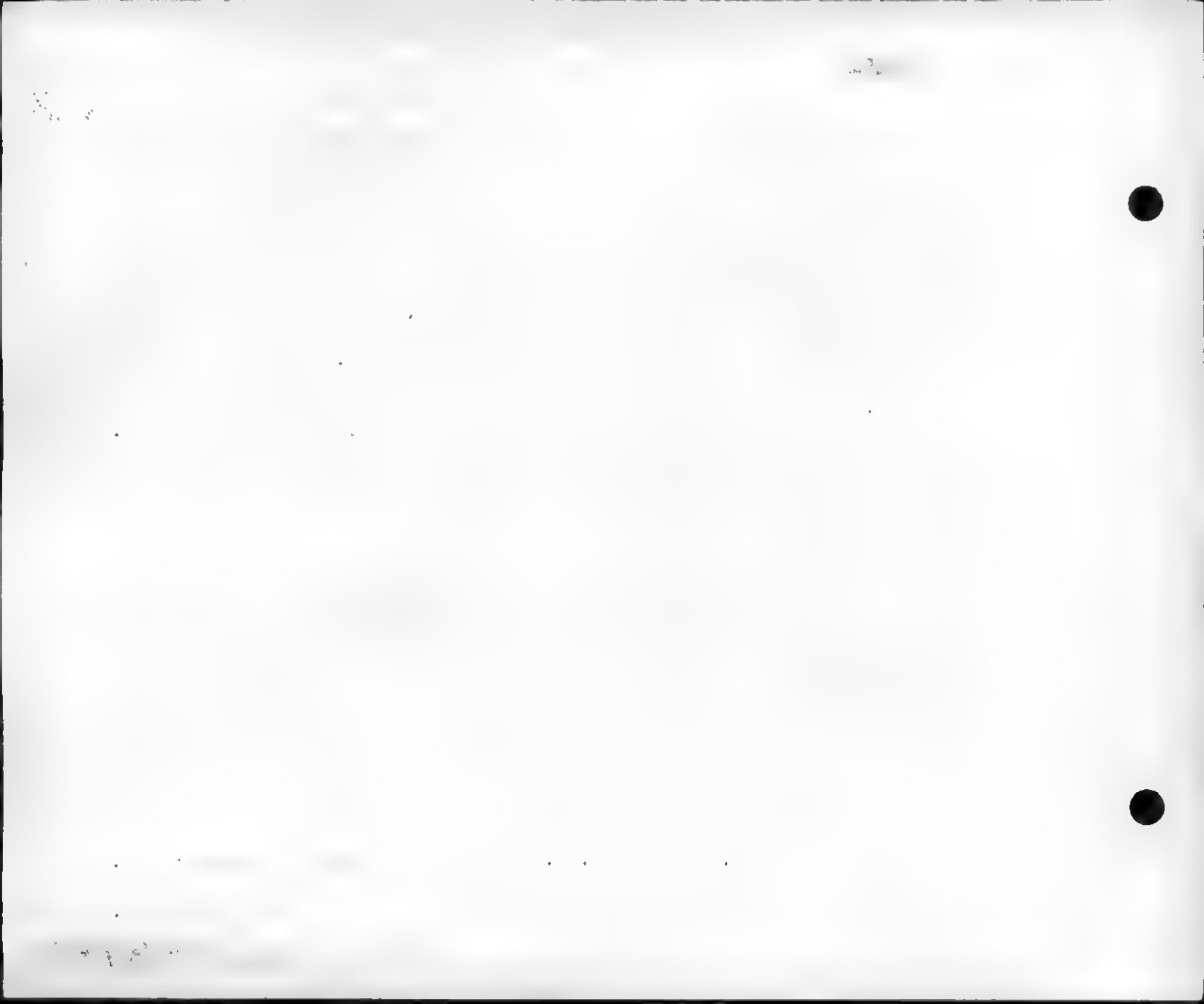
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08503

CERTIFICATE OF DEATH

08497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN <u>4 hrs 38 min</u> <u>Suitland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				e. STREET ADDRESS <u>3926 Suitland Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy "B"</u> Middle <u>Waddell</u> Last <u>Waddell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1967</u>		9. AGE (In years last birthday) <u>4</u> yrs	10. UNDER 1 YEAR Months <u>4</u> Days <u>38</u>	11. UNDER 24 HRS Hours <u>4</u> Mins <u>38</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger L. Waddell</u>				14. MOTHER'S MAIDEN NAME <u>Cheryl Crider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>N/A</u>		17. INFORMANT <u>Road, Suitland Address Md.</u> <u>CPL Roger L. Waddell, USMC, 3926 Suitland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity, 700 grams; Atelectasis (lungs)</u> <u>162.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>June 2, 1967</u> that (X) (we) last saw the deceased alive on <u>June 2, 1967</u> , and that death occurred at <u>1215M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ronald F. Swanger</u>				P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ronald F. Swanger, M. D.</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transfer</u>		23b. DATE THEREOF <u>2 June 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Naval Medical School</u>		23d. LOCATION (City or Town) (County) (State) <u>NNMC, Bethesda, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE <u>JUN 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

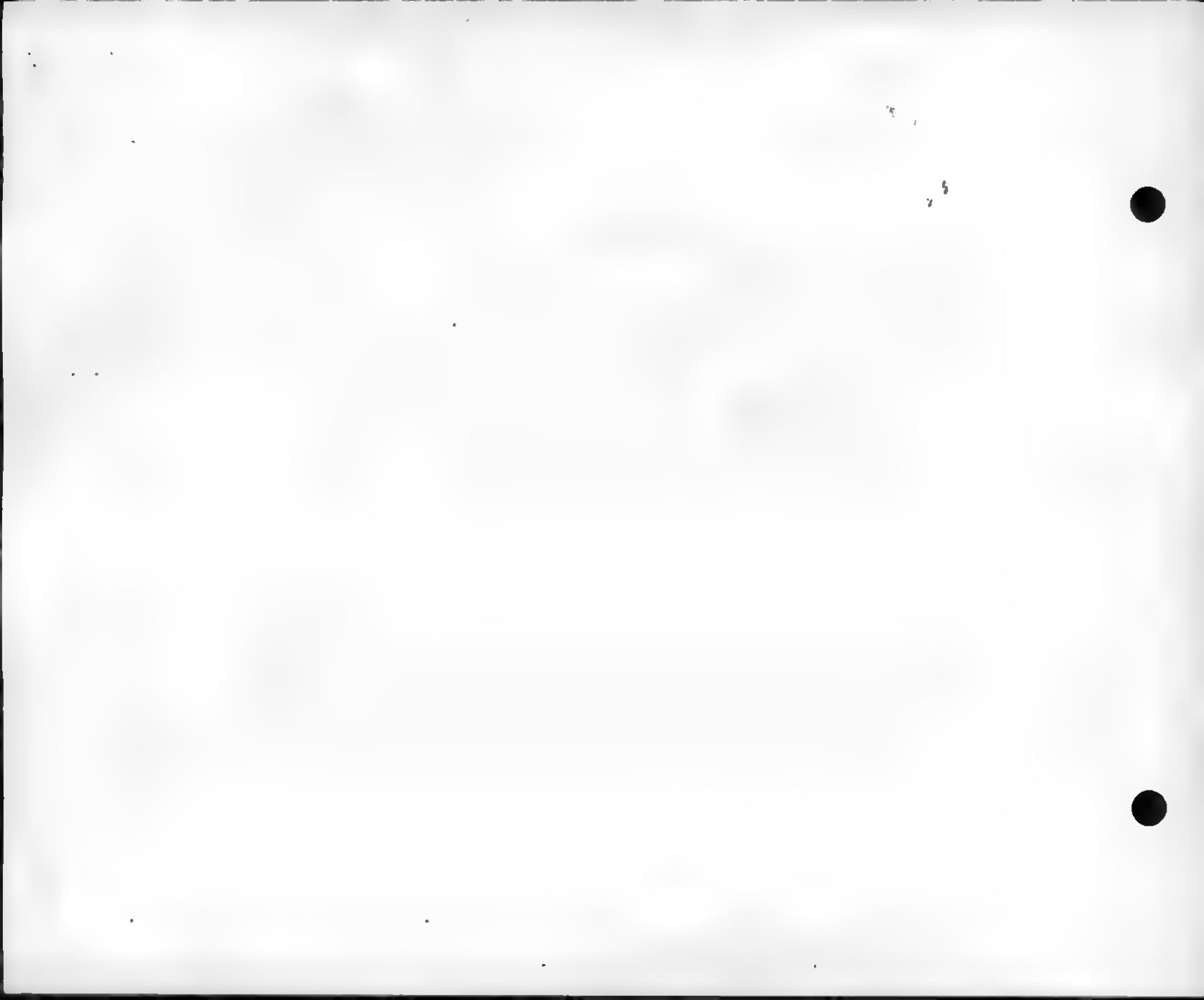
08504

08498

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTG.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. LENGTH OF STAY IN 1b 13			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURSING HOME				d. STREET ADDRESS 8120 SEVEN LOCKS RD.			
3. NAME OF DECEASED (Type or print) First RAVA Middle WARE Last WARE				4. DATE OF DEATH Month JUNE Day 24 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 10, 1900	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 13 Days 14 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. LABORER		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY WARE				14. MOTHER'S MAIDEN NAME ESTELLA JACKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <input type="checkbox"/>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Car Pulmonary DUE TO Chronic Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Bronchitis (c) 2 yrs +						INTERVA. BETWEEN ONSET AND DEATH 2 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/1/67 , 19 67 , to 6/24/67 , 19 67 , that (I) (we) last saw the deceased alive on 6/18/67 , 19 67 , and that death occurred at 2:00 M, from causes and on the date stated above							
22a. SIGNATURE Henry C. Snuggs M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/25/67	
22c. PHYSICIAN'S NAME (Type) 5413 Cedar Lane Bethesda, Md.				22d. ADDRESS HENRY C. SNUGGS M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/29/67		23c. NAME OF CEMETERY OR CREMATORY FISHERMAN, S CEM.		23d. LOCATION (City or Town) (County) (State) ROCKVILLE, MD.	
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS ROBERT L. SNOWDEN ROCKVILLE, MD.				25a. REC'D BY REGISTRAR DATE JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #100-572-101 pc

CERTIFICATE OF DEATH

Items 14, 23b, c, d - Film #100-710/67mnb

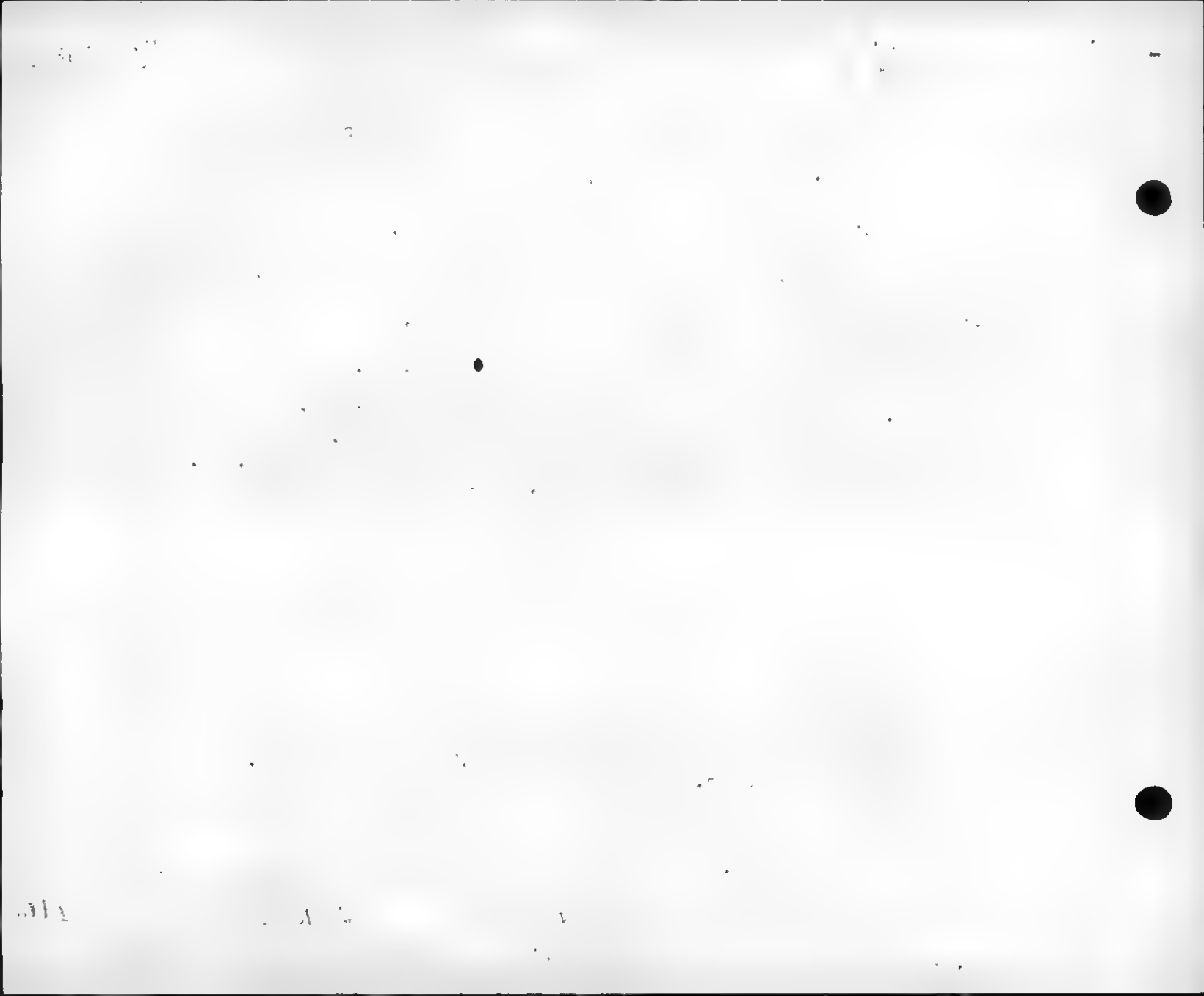
08505

08499

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Indiana b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN TB 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Rt. 1	
3. NAME OF DECEASED (Type or print) Louise Allen Warren		4. DATE OF DEATH Month June Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1904
9. AGE (In years last birthday) 62 63/ yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Conroe, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ben P. Allen		14. MOTHER'S MAIDEN NAME Mary Louise March	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 304 40 6832	
17. INFORMANT Seral Warren		Address Rt. 1 Valparaiso, Ind. 46385	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST DUE TO (b) 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun. 9 , 19 67 , to Jun. 9 , 19 67 that (I) (we) last saw the deceased alive on Jun. 9 , 19 67 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>William R. Hix</i>		22b. DATE SIGNED 11 June 1967	
22c. PHYSICIAN'S NAME (Type) William R. Hix MD		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/14/67	23c. NAME OF CEMETERY OR CREMATORY LaCrosse Cemetery	23d. LOCATION (City or town) (County) (State) LaCrosse, Ind.
24. FUNERAL DIRECTOR R.A. Pumphrey Funeral Home		25. REC'D BY REGISTRAR JUN 16 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

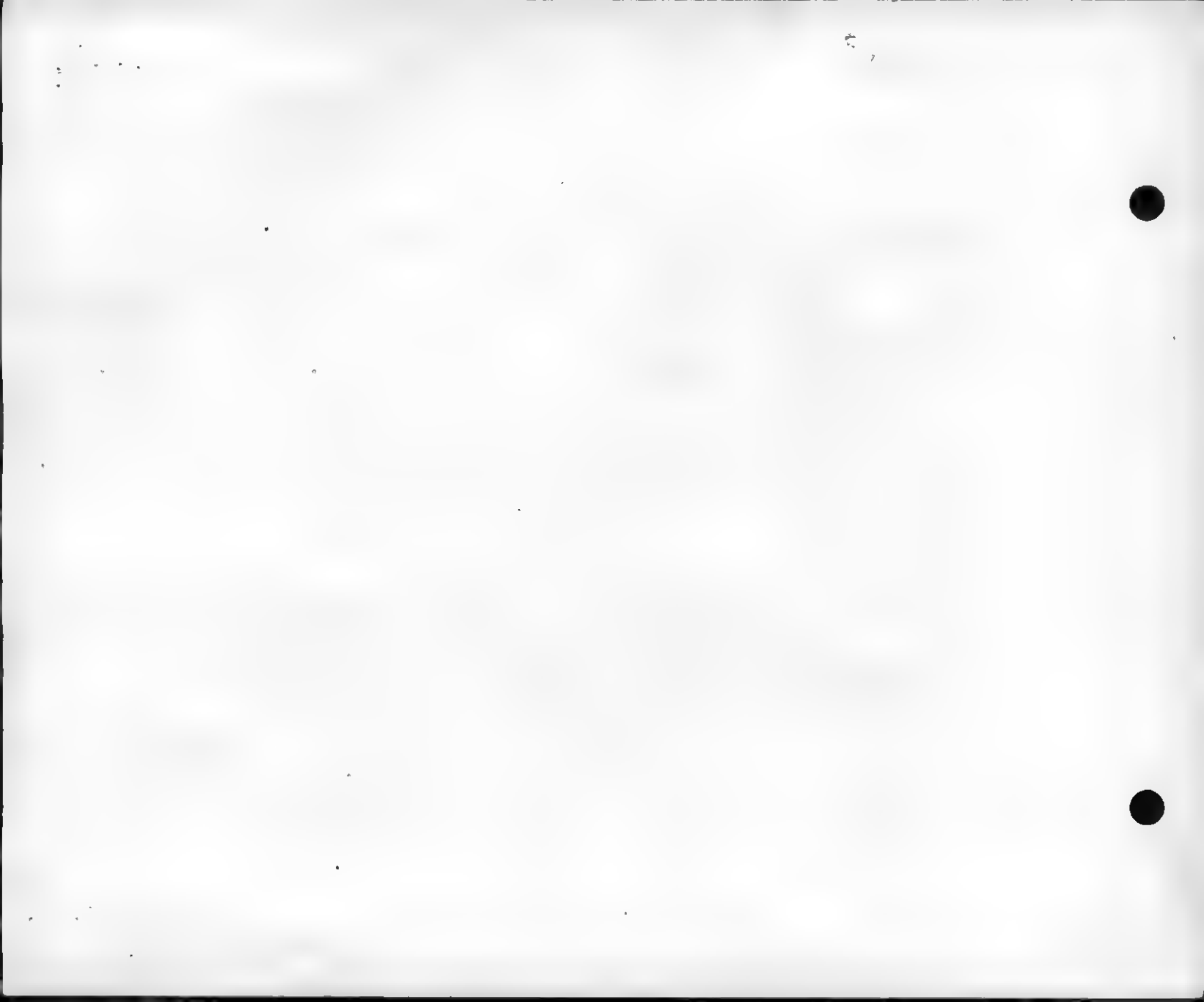
Item #8 Film #0380 1/16/67

08506

CERTIFICATE OF DEATH

08500

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>17 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospt.</u>				d. STREET ADDRESS <u>18471 Brooke Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINERVA</u> Middle <u>NN</u> Last <u>WASHINGTON</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/24 93</u>	9. AGE (in years last birthday) <u>73</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Selby</u>				14. MOTHER'S MAIDEN NAME <u>Christianna Budd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>578-26-5303</u>		17. INFORMANT <u>Medical Records of Montg. General Hospt.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>years.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>6/6/67</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>67</u> , and that death occurred at <u>8:10</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Yates</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard Yates</u>				22d. ADDRESS <u>Olney, Md. 20832</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHARP STREET CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>SANDY SPRING, MONTG. MD.</u>	
24. FUNERAL DIRECTOR <u>George R. Brumbaugh</u>				25a. FILED BY REGISTRAR <u>14</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08507

CERTIFICATE OF DEATH

08501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Greenbelt, Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt, Md.</u> d. STREET ADDRESS <u>22A Hillside Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bertrand Angus Wells</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-15-1899</u> 9. AGE (In years lost birthday) <u>67</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Danville Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S</u>				4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1967</u> 13. FATHER'S NAME <u>Charles Wells</u> 14. MOTHER'S MAIDEN NAME <u>Ida</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>216-09-0762</u> 17. INFORMANT <u>Wife Mrs Esther L. Wells (same as #2)</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>2-3 yrs.</u> (c) <u>Atherosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FREQUENT PREMATURE CONTRACTIONS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1962</u> to <u>JUNE 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 13, 1967</u> , and that death occurred at <u>11:16</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Irey</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u> 22d. ADDRESS <u>11161 New Hampshire Ave, Silver Spring</u>				22b. DATE SIGNED <u>6-13-67</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JUNE 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR <u>William Walters</u> ADDRESS <u>254 Canal St NW, Wash. DC</u>				25a. REC'D BY REGISTRAR <u>JUN 15 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

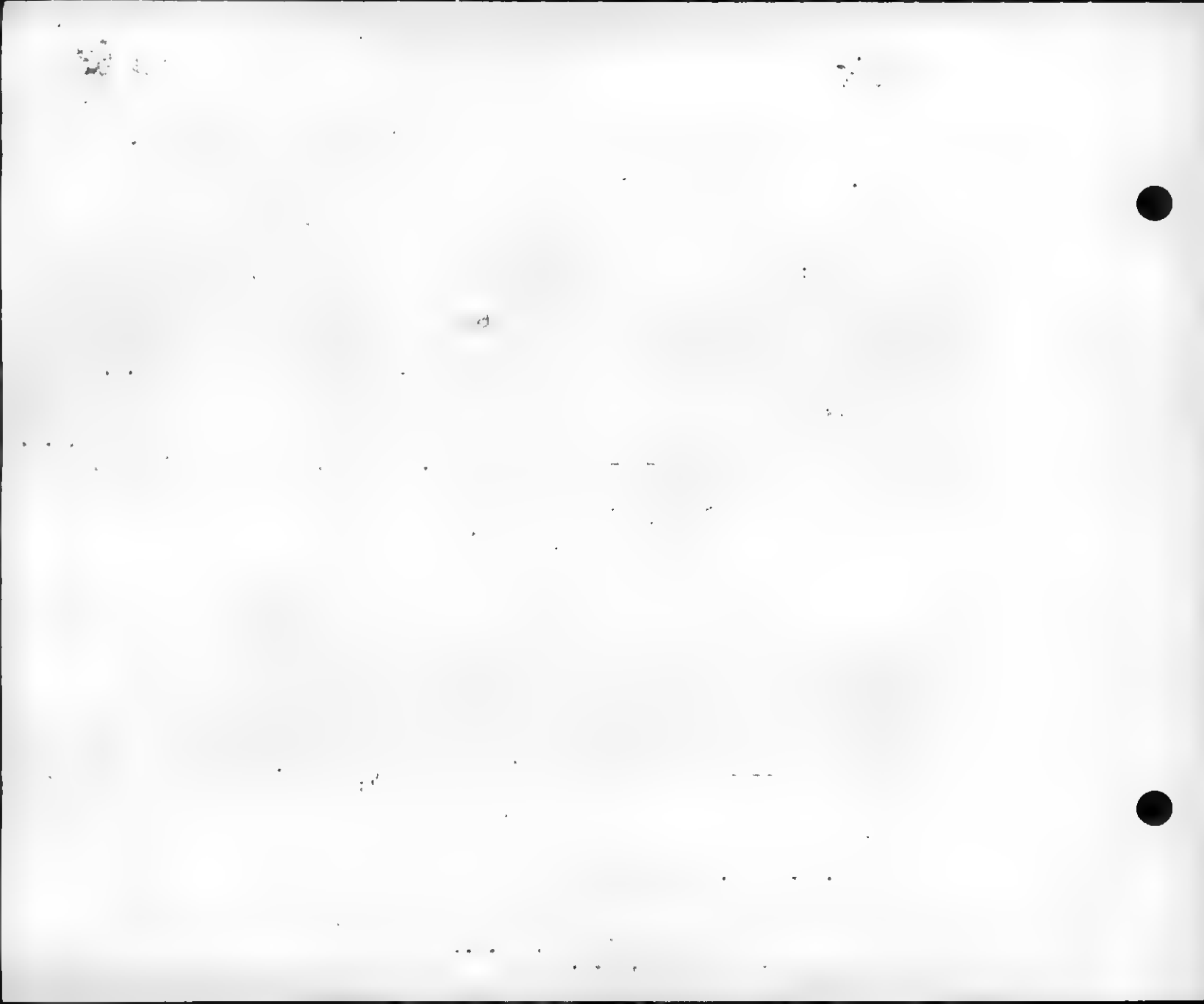
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08508

CERTIFICATE OF DEATH

08502

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN it 2hrs 40min			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e. STREET ADDRESS 8940 Jones Mill Road			
3. NAME OF DECEASED (Type or print) First Marion Middle Leigh Last WELLS				4. DATE OF DEATH Month June Day 3 Year 1967			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Aug 1884	9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gentlewoman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sidney, Australia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sir Hugh Dixon				14. MOTHER'S MAIDEN NAME Emma Elizabeth Shaw			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-2607		17. INFORMANT (Attorney) Andrew T. Altmann, Colorado Building, Address Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarct DUE TO subintimal hemorrhage, right coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of liver DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 5:50AM 3 June 1967 , to 4:30 AM 3 June 1967 that (X) (we) last saw the deceased alive on 3 June 1967 , and that death occurred 4:30A M. from causes and on the date stated above.							
22a. SIGNATURE J. E. Goss LCDR, MC, USNR				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3 June 1967	
22c. PHYSICIAN'S NAME (Type) J. E. GOSS, LCDR MC USNR				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-7-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR 5130 Wisconsin Ave., N.W., Gawler Funeral Home, Washington, D.C.				25a. REC'D BY REGISTRAR JUN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

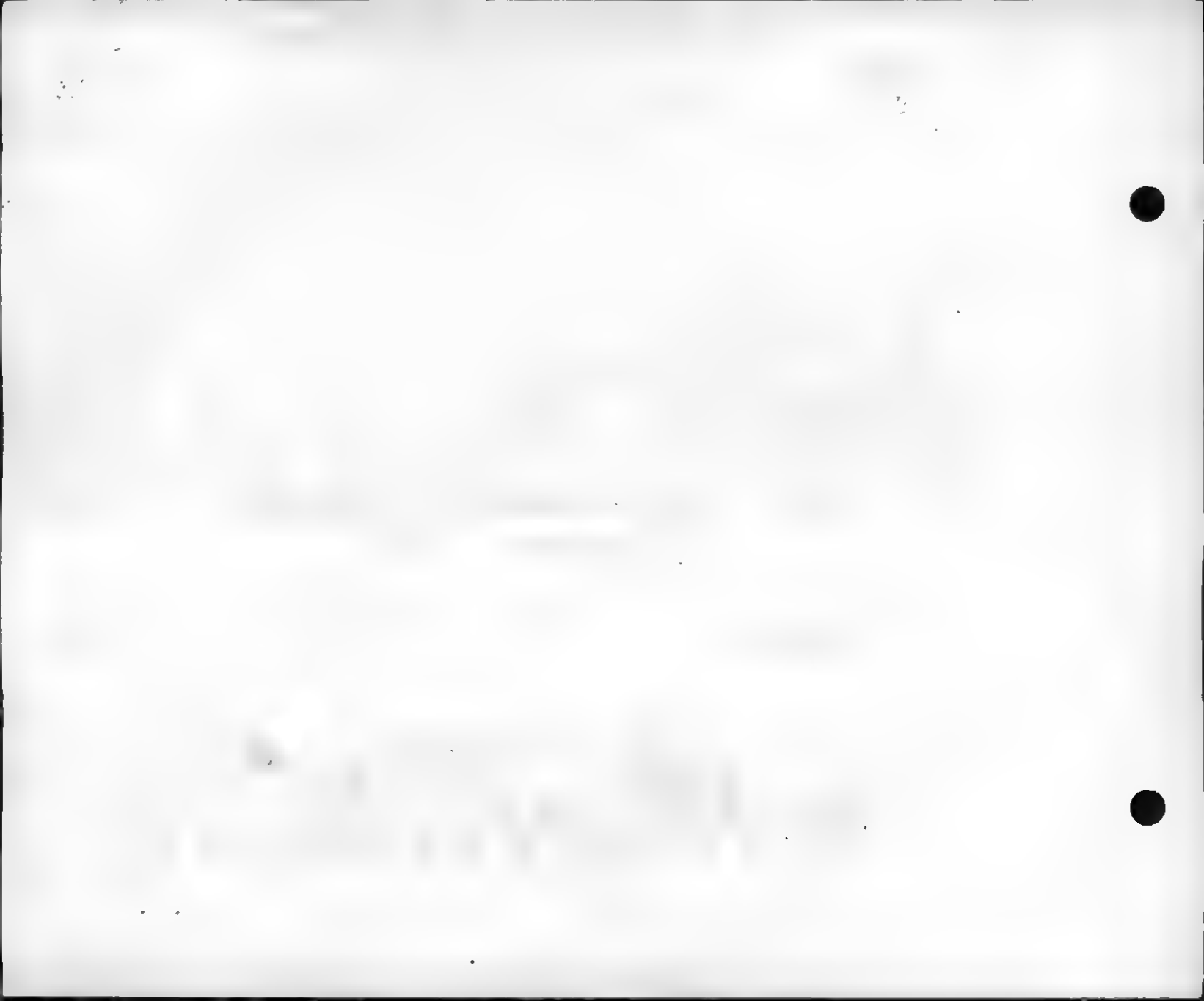
08503

08503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 12628 Layhill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle m. Last Werck				4. DATE OF DEATH Month 6 Day 23 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/81		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (County & State, or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Werck				14. MOTHER'S MAIDEN NAME 			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-50 7362		17. INFORMANT Josephine Werck Address College Park Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5410 Gastrointestinal Neuronhege DUE TO Duodenal Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 0 m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/8/67 to 6/23/67 , that (I) (we) last saw the deceased alive on 6/23/67 19 67 , and that death occurred at 240 P M, from causes and on the date stated above.							
22a. SIGNATURE Henry C. Scruggs M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/23/67	
22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS				22d. ADDRESS 5413 Cedarlane Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 28 1967	
				25b. REGISTRAR'S SIGNATURE 			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08510

08504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Claude Middle W. Last Wessells		4 DATE OF DEATH Month June Day 22 Year 67	
5 SEX male	6. COLOR OR RACE cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 28, 1902
9 AGE (In years last birthday) yrs 64		10 IF UNDER 1 YEAR Months 6 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supt.		10b. KIND OF BUSINESS OR INDUSTRY PEPCO	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Wessells		14. MOTHER'S MAIDEN NAME Mary Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577-09-3011	
17. INFORMANT Jessie A. Wessells		Address 6903 20th Ave. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Metastases DUE TO (b) Primary Lung Carcinoma with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 1-2 YEARS			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 HOURS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October, 1965 , to June 22, 1967 , that (I) (we) last saw the deceased alive on June 20, 1967 , and that death occurred at 5:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Hugo G. Graziani, M.D.		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) Hugo G. Graziani, M.D.		22d. ADDRESS 10101 Georgia Ave S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/26/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR The S.H. Harris Co		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JUN 23 1967	

Walter W. Wessels

on

Harry Nelson

577-09-3011essale v. Wessels-6003 20th Ave.
Hattaville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

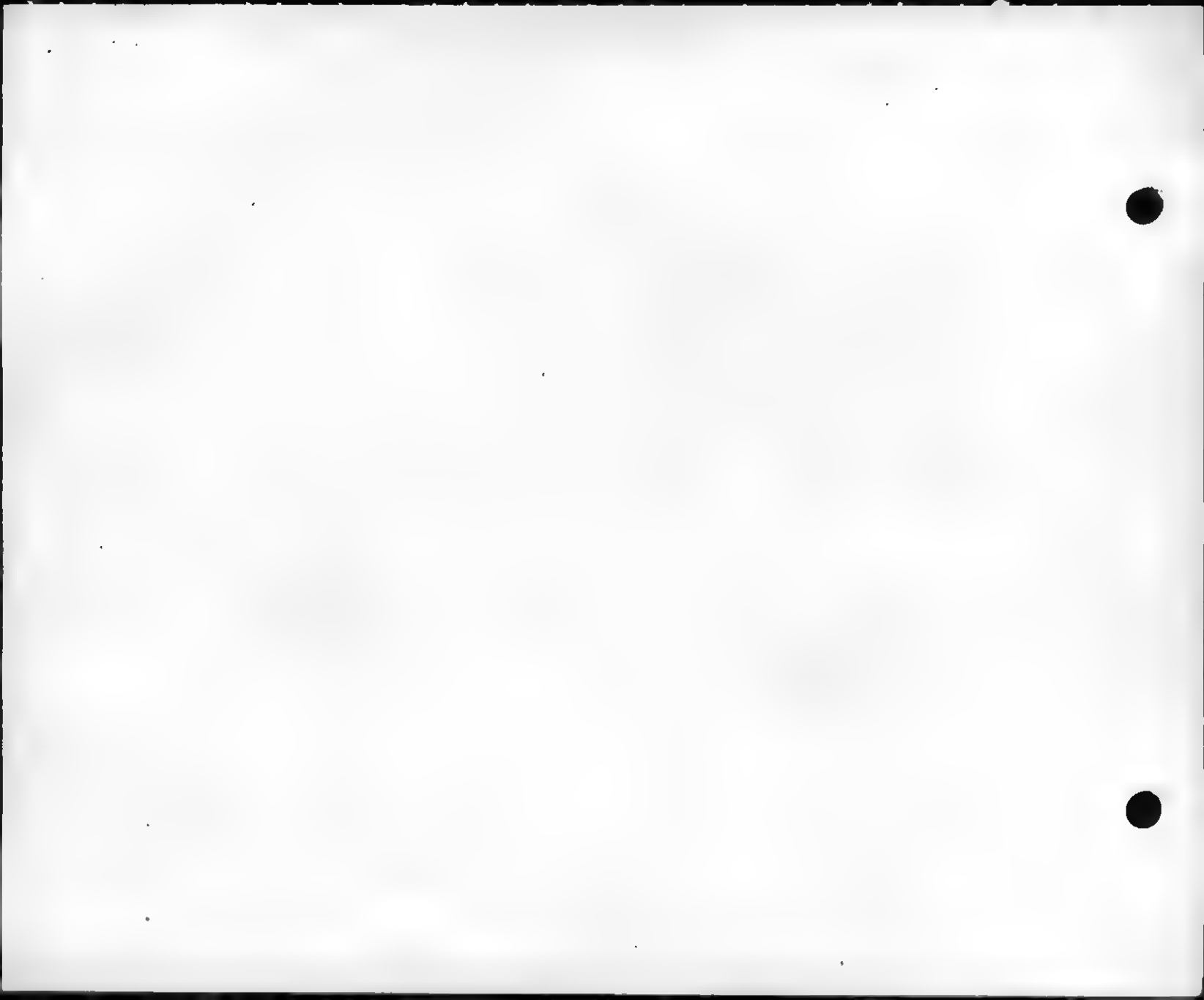
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Item #13 Film #G400 377 167 pc

CERTIFICATE OF DEATH

08505

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IB <u>20 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>1514 Madison Street</u>	
3 NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Mae</u> Last <u>Wheelless</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 August 1917</u>
9 AGE (In years last birthday) <u>49</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11 BIRTHPLACE (County & State or foreign country) <u>Georgia</u>	
13. FATHER'S NAME <u>Charlton Carrington Spells</u>		14. MOTHER'S MAIDEN NAME <u>Emma Guthrie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>237-30-4529</u>	
17. INFORMANT <u>The Medical Records</u>		18. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis and pneumonia with partial atelectasis</u> DUE TO (b) <u>Bilateral pleural effusion with massive ascites</u> DUE TO (c) <u>Focal necrosis and fatty metamorphosis of the liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10</u> days <u>weeks to months</u> <u>months to years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>22 May</u> , 19 <u>67</u> , to <u>11 June</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11 June</u> , 19 <u>67</u> , and that death occurred at <u>9:30 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David F. Paulson</u>		22b. DATE SIGNED <u>12 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>David F. Paulson, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lovein Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Nashville, Ga.</u>	
24. FUNERAL DIRECTOR <u>Home Inc. Nalley's Funeral</u>		25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>	
ADDRESS <u>Mt. Rainier, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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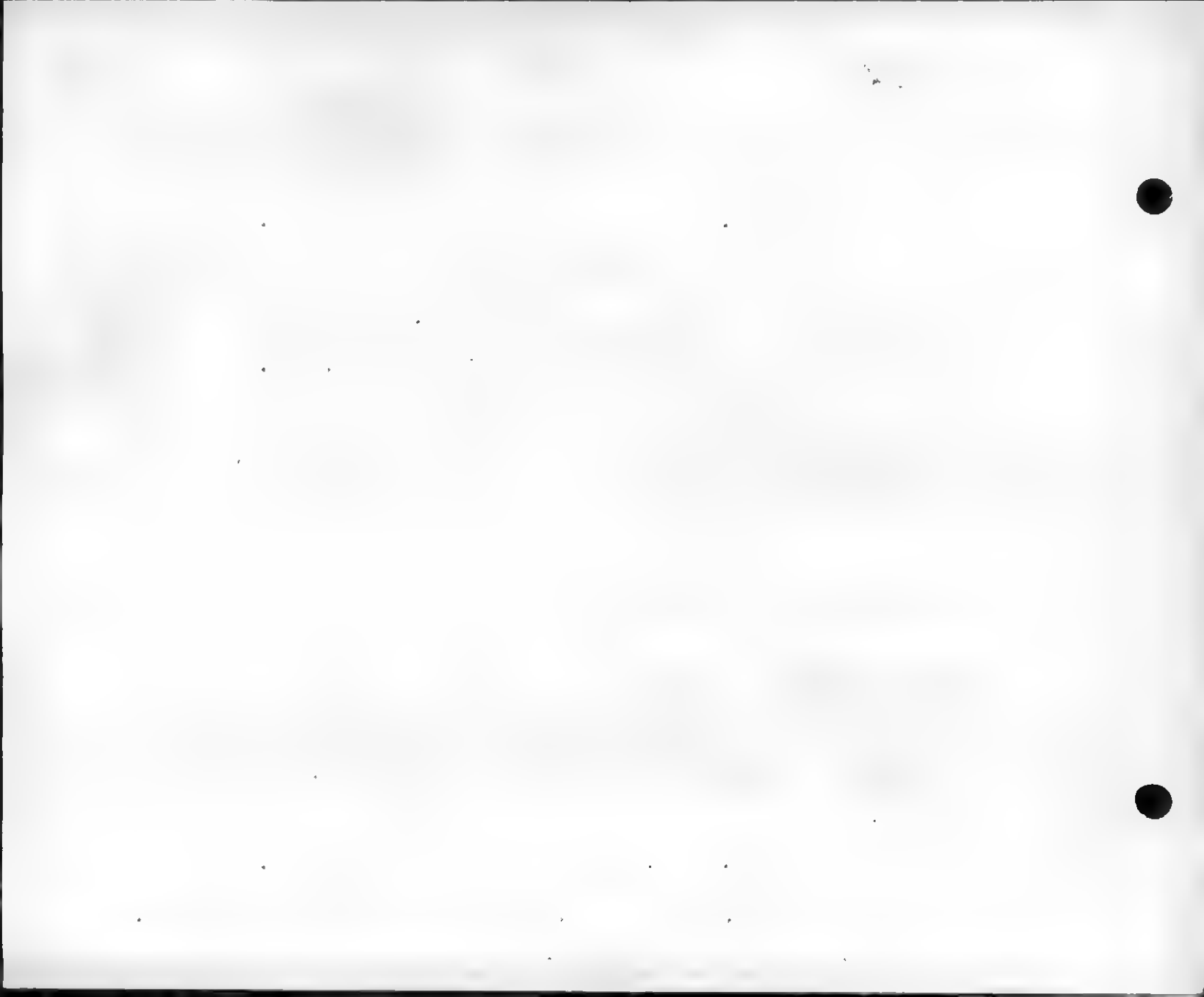
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08512

CERTIFICATE OF DEATH

08506

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9069 Main St.		d STREET ADDRESS 9069 Main St.	
3 NAME OF DECEASED (Type or print) Margaret Elizabeth Whiteman		4 DATE OF DEATH Month June Day 26 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1882
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Belle Plain, Kan.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornwell		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-0068	
17. INFORMANT Richard C. Whiteman,		Address Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 YEARS			INTERVAL BETWEEN ONSET AND DEATH 2 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/15 , 19 67 , to 6/26 , 19 67 , that (I) lost saw the deceased alive on 6/24 , 19 67 , and that death occurred at 4 A.M. from causes on and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 6/28/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Frederick, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REG'D BY REGISTRAR DATE JUN 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

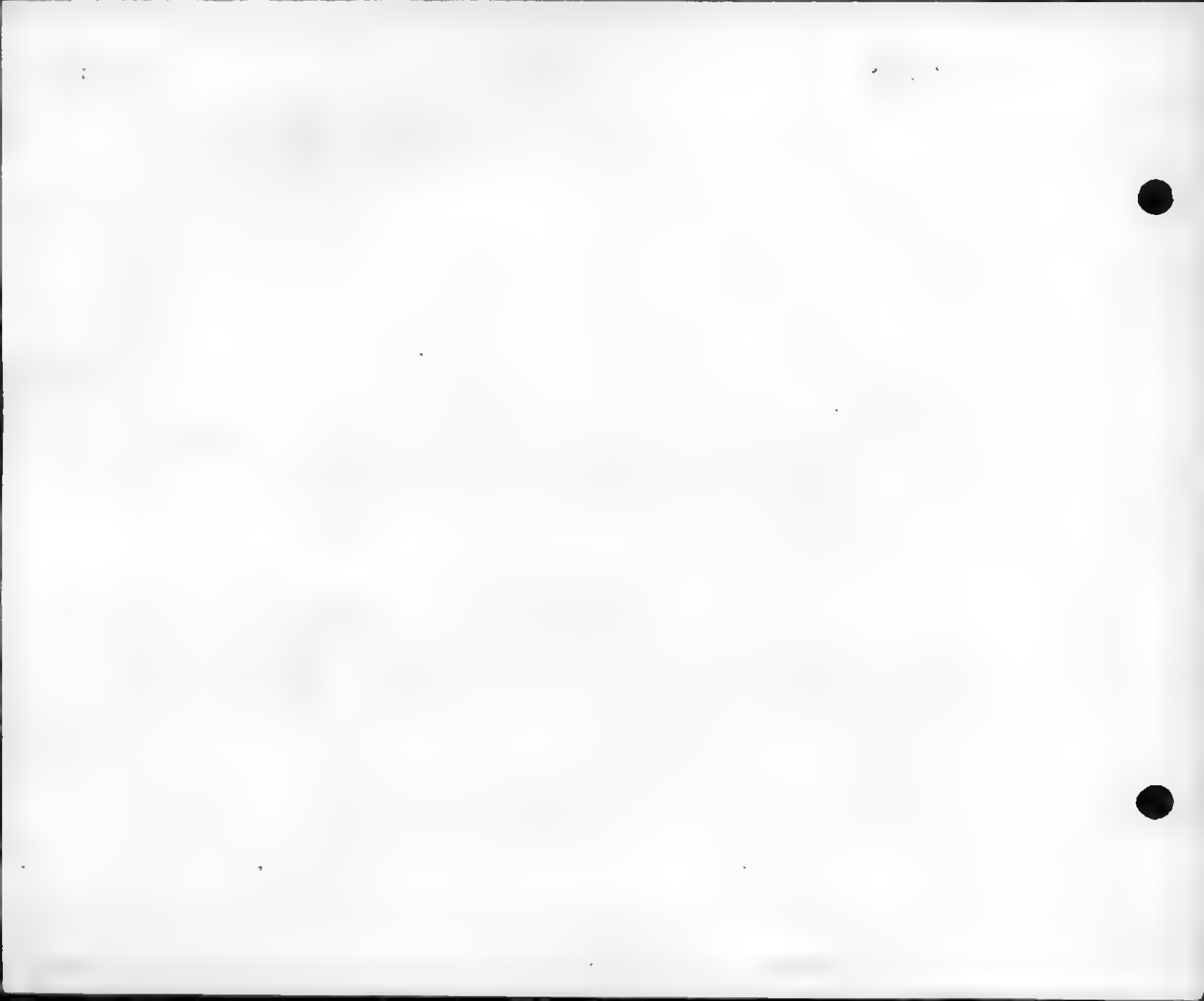
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08507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>1940 Kimberly Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Augusta Helen Wickham</u>		4. DATE OF DEATH <u>June 24 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/16</u>
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wushnak</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lasanska</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>577-10-0610</u>	
17. INFORMANT <u>Guy J. Wickham</u>		Address <u>1940 Kimberly Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> <u>1008</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1008</u> DUE TO (c) <u>1008</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> , to <u>6/24 1967</u> , that (I) (we) last saw the deceased alive on <u>6/23 1967</u> , and that death occurred at <u>9:24 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Eig</u>		22b. DATE SIGNED <u>6/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Blaine H. Eig</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Glen Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

38514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08508

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY In <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN & HOSP</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WALTER BLAINE WILLIAMS SR.</u>		4 DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-18-01</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>SAM. H. WILLIAMS</u>		14 MOTHER'S M A D E N NAME <u>ELLA BAILEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16 SOCIAL SECURITY NO <u>409-28-0884</u>	
17 INFORMANT <u>CLARENCE WILLIAMS - SON</u>		18 CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease.</u>		(c) <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
24a B. R. I. A. CREMATION, REMOVAL (Specify) <u> </u>		24b DATE THEREOF <u>June 21-1967</u>	
24c NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		24d LOCATION (City or town) (County) (State) <u>Laurens Co. South Carolina</u>	
24e FUNERAL DIRECTOR <u>Arthur Walters</u>		24f ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20002</u>	
25a REC'D BY REGISTRAR <u> </u>		25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>	
DATE <u>JUN 21 1967</u>		DATE <u>6/19/67</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

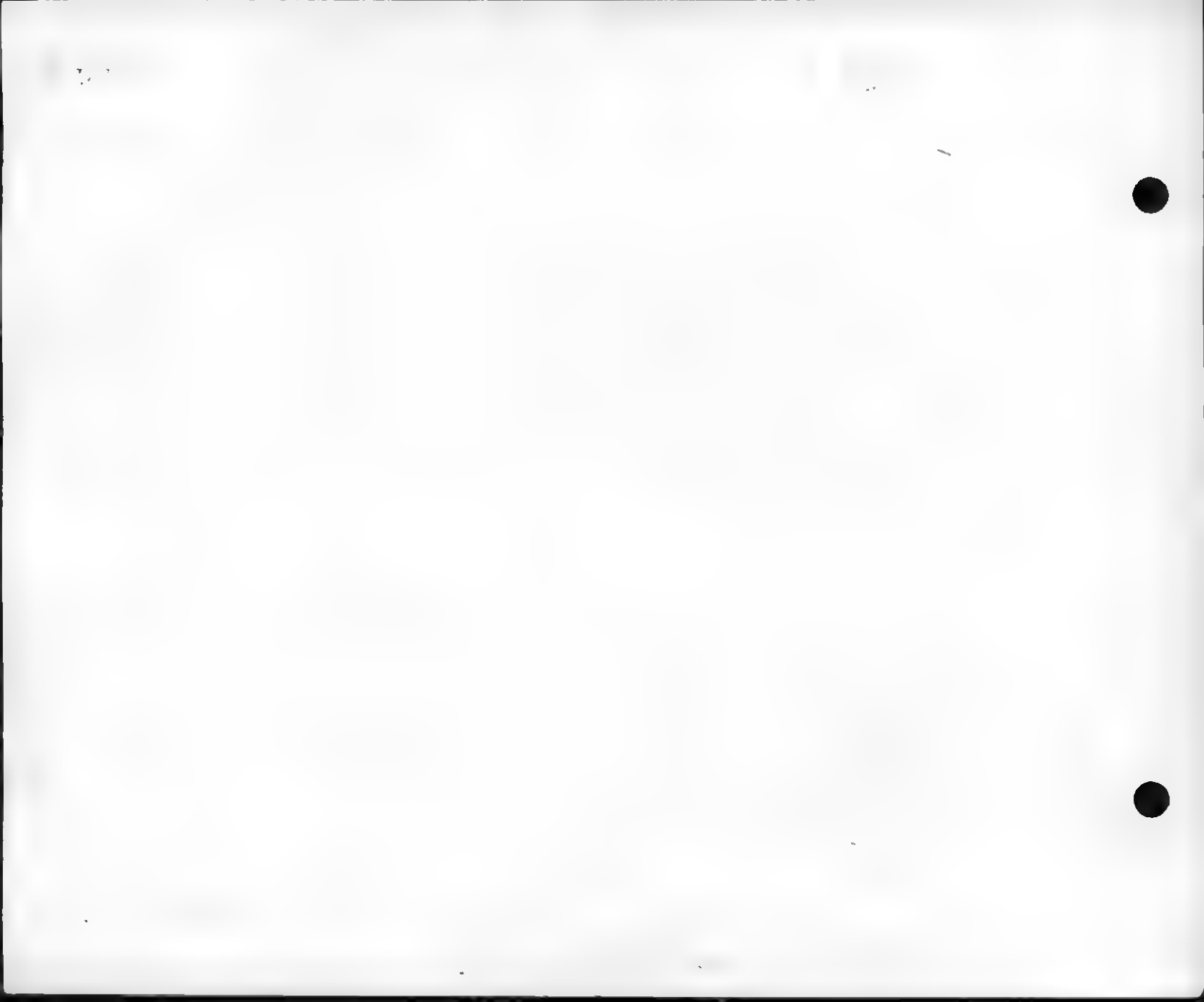
VR A15ME (5)
6M 1/67

38515

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08509

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>				c LENGTH OF STAY in 1b <u>10 yrs</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <u>10820 Georgia Ave</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Claude Abraham Wood</u>				4 DATE OF DEATH <u>June 3 1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 28, 1901</u>	9 AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTH-PLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Abraham Wood</u>				14. MOTHER'S MAIDEN NAME <u>Eva Twyman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>710-18-4816</u>		17. INFORMANT <u>WIFE</u>		Address <u>10820 Georgia Ave S.S.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Neap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>June 4, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (City, town, or county) <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or town, County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u>		Address <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>	
DATE <u>JUN 8 1967</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08516

CERTIFICATE OF DEATH

08510

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			d. STREET ADDRESS 206 Russell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Yankey, Loy Allen Yankey			4. DATE OF DEATH Month 6 Day 14 Year 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/04		9. AGE (In years last birthday) yrs. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller		10b. KIND OF BUSINESS OR INDUSTRY Mill		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME William Yankey			14. MOTHER'S MAIDEN NAME Victoria Halterman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records Address Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastasis 177X DUE TO Carcinoma of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-27 , 19 67 , to 6-14 , 19 67 that (I) (we) last saw the deceased alive on 6-13 , 19 67 , and that death occurred at 5:40 P.M. from causes and on the date stated above.					
22a. SIGNATURE Baltazar E. Perez			22b. DATE SIGNED 6-14-67		
22c. PHYSICIAN'S NAME (Type) Baltazar E. Perez			22d. ADDRESS 10305 Folk St., Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 17 1967		23c. NAME OF CEMETERY OR CREMATORY Flower Hill	
		23d. LOCATION (City or Town) Derwood		(County) (State) Montgomery Md.	
24. FUNERAL DIRECTOR Francis H. Barber			ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR JUN 16 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge		

Francis M. Barber
Lynchville, Va.
June 17, 1921
Lower Hill

Wood
Montgomery, Ala.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-21 Film 390
7-18-67 am

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08511

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>6903 Tilden Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>SOONG</u> Last <u>YAPLEE</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Orantal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1924</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Industry</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Soong YAPLEE</u>				14. MOTHER'S MAIDEN NAME <u>Fung Ying</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Brother - Benjamin Yapple</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.4 Peritonitis acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Fecal impaction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>48 hrs.</u> <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sedation with high doses of Thorazine</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Bell</u>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>6/4/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-12-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

5130 Wisc. Ave. N.W. Wash. D.C. DATE JUN 12 1967

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